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CHC

PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH

Implemented by:

MINISTRY OF
HEALTH AND FAMILY WELFARE

Guided & Monitored by:

NATIONAL INSTITUTE OF
HEALTH AND FAMILY WELFARE

Assisted by:

UNITED STATES AGENCY
FOR INTERNATIONAL DEVELOPMENT

02033

A.V.R.V. FOUNDATION OF AYURVEDA
P.V.O.H. PROJECT OF GOI/MOHFW

DESCRIPTION OF THE PROJECT:- The project area consists of Perianaickenpalayam Panchayat Union Block and Karamadai Panchayat Union with a total polulation of 1,51,532. The pilot area covering 26,000 people consists of 4 villages. Nearly 10 percent of the population are industrial labourers. A sizeable percentage of the population belongs to hill tribes. The major problems faced by the community are diseases caused due to malnutrition, tuberculosis, worm infestation, leprosy, bronchial problems and anaemia. The question sought to be answered was to identify what Ayurveda and Siddha can do at the primary health care level as an alternative to the existing health care serviçes.

STRATEGY:- The objectives of the project were sought to be achieved by the delivery of out-reach health services through the following components:-

Rural Health Centre (RHC), Satellite Health Unit (SHU)
Village Health Post (VHP) & Mobile Supervisory Team (MST).

RHC:- Rural Health Centre situated near the Ayurveda College at Patanjalipuri operated as Administrative Centre for the project provided free OPD and also in-patient treatment. It provided family planning services and conducted training for the project staff and community. It produced herbal medicines through the drug unit for supply to the community.

SHU:- There are four satellite units covering 26,000 people. These units functioned under direct supervision of RHC and are managed by Ayurveda Physician/Siddha Physician, ANM and Compounder. They provided basic health care and family planning services and attended to emergencies.

VHP:- This is a micro level unit of the project and is a crucial link between the community and project officials. Trained health promoters use their home as peripheral services unit to identify and assist families requiring treatment at the Satellite units. They provided necessary know-how to the community in cultivation and preparation of simple herbal medicines.

(Assisted by the U.S.A.I.D.)

A.V.R.V. FOUNDATION OF AYURVEDA

P.V.O.H. PROJECT OF GOI/MOHFW

The AVRV Educational Foundation of Ayurveda: This foundation is a non-governmental, non-profit making voluntary organisation established in 1978 as a registered society in the sacred memory of the Late Sri P V Rama Varier, an outstanding Ayurvedic Physician, a great Scholar and humanitarian all rolled into one. It is sponsored and promoted by the Arya Vaidya Pharmacy (CBE) Ltd., and the Ayurvedic Trust of Coimbatore, Tamil Nadu. The organisation has developed over the years into a complex institution having all the infrastructure facilities resources and systems needed for carrying out its objectives, and under its auspicies a series of research projects were launched and are still on going. COMPREHENSIVE RURAL HEALTH PROJECT sanctioned by the Ministry of Health and Family Welfare, Government of India was started in 1984. The project was originally sanctioned for a period of 5 years and was subsequently extended for one year and nine months. The project ends on 30th September 90. The total project cost is Rs. 60,70,185/- out of which 75% is US AID and 25% is organisation contribution. Seventyfour people including technical and non-technical staff and Village Health Promoters are employed under this project.

OBJECTIVES OF THE PROJECT:- The objectives of the project are to improve the rural health services through innovative alternative methods and operations by integrating traditional systems of medicines viz., Ayurveda and Siddha in primary health care. It is envisaged to enhance the quality of life by improving the health status of the people of the project area by enabling them to take care of their own health through self reliance by dissemination of relevant knowledge and skills and increasing the level of health consciousness especially health care of mothers, children and people in old age. This project has an integrated approach towards management of health through the preventive, curative and promotive aspects. In the context of the goal of health for all by the year 2000 with the Primary Health Care approach, the AVREFA, Coimbatore undertook the Comprehensive Rural Health Project at Pathanjalipuri, Coimbatore with the aim of making health care, more relevant to the needs of the society and to improve the services to the public at large and make better health care a reality.

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MOBILE TEAM:- This consisted of Physicians and para-medical staff and supervised the SUs and VHPs at frequent intervals. Besides identification of referral cases it carried out health education activities through audio-visual aids.

DOCUMENTATION:- The documentation unit attached to the centre developed Audio-visual materials helped in conducting of health education especially using slides and videos. They consolidated reports and identified issues that need to be attended to.

ACTIVITIES AND SERVICES:- The specific project activites are the following :- Improvement in nutritional and health status of children, preganant and lactating mothers, health education, health practices for promoting of healthy babies, promotion of breast feeding, utilisation of local farm products, development of healthy food habits, immunization to children and pregnant women, prevention of communicable diseases and environmental sanitation practices. The project provided curative out-patient and in-patient services, referral services from the Health Promoters to health unit and to the Rural Health Centre. Mobile unit operated especially in tribal area providing curative and health education services. MCH care through ANC clinics, contacts with AN and PN mothers, delivery at RHC and assistance in home delivery, school and Balawadi health programme and immunization were also carried out. Training and orientation was carried out on an ongoing basis to the staff and community. Councelling was done wherever needed. Health education was carried out as an integral part of all programmes to promote local health traditions.

BASELINE SURVEY:- A Baseline Survey covering 100% of the house holds in the pilot area was conducted. Framing of questionnaires, Field Testing, Training of Data Collectors and Supervisors, Data Collection, Data analysis and preparation of Survey reports was done.

COMMUNITY PARTICIPATION:- Community participation is viewed as a process that involved the community in activities that promotes self reliance in health care. The stress here is in enabling the community to take care of their own health problems in ways that they feel are appropriates.

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A.V.R.V. FOUNDATION OF AYURVEDA
P.V.O.H. PROJECT OF GOI/MOHFW

This was done by various means such as locating the health units in places determined by the community on basis of convenience of the community, involving health promoters as animators in the community who are identified by the community from amongst them, involvement of traditional practitioners, dais and housewives in the programme for the promotion of local health traditions, involving youth and women and others in organising the community for various field level programmes.

MEDICINAL PLANTS AND HERBAL GARDENS:- The locally available medicinal plants and its local uses were documented and horizontal communication , of knowledge and skills on availability and use of medicinal plants were set into motion at village level where the experiences are shared and common understandings developed.

CONCLUSION - On a general assessment it has been observed that there is definite improvement in the incidents of such health problems in the project area as already referred to and there has also been reduction in child mortality rate and maternal mortality rate. It has become clear from the project experience that there exists a vast amount of knowledge, skills and resources that people can use and will be able to use for a wide range of health problems in a safe manner. This has to be catalysed and strengthened by providing mobilisation of interests and information. PVOH-I being only for a short period of 6 years and there having been no model, it took a lot of time to begin to roll on its own wheels and it has set a line of action and opened up a grand question for the future to seek. It is evidently felt that much is left to be done. Our suggestion is that this kind of project should not be treated as a one time action and the fruit of what has been achieved and what has already been done should be carried forward to the benefit of the people either in the same project area or elsewhere and further researches documentation and dissemination should be carried out to evolve an ideal model primary health care to be followed by other organisations in other parts of the country in the larger interest of the people of India which can be the base for evolving a better and more fruitful national health policy by the Government of India. Even after the closure of the project we will be doing what little we can in this direction.

(Assisted by the U.S.A.I.D.)

BAL RASHMI SOCIETY, JAIPUR
P.V.O.H. PROJECT OF GOI/MOHFW

Bal Rashmi Society started working for the welfare of children in 1972. It started with an Awasiya School with 4 Harijan children. The child care activities soon grew up and there are 40 Harijan children in the Awasiya School, 125 in Destitute Children's Home, 8 in Bhavisya Nirman Kendra and 30 abandoned infants in the Kilkari Fondling Home. Bal Rashmi established its campus in 1982 at Mansar Khedi and took up relief and rehabilitation work amongst the flood affected people by building 254 houses in 14 villages and 106 for slum dwellers in Jaipur. 8 wells and 10 ponds were built and 20 wells and 10 ponds desilted to augment drinking water resources.

In the villages Bal Rashmi came face to face with the problems the people were having in respect of education, health care, employment and ignorance and so its activities were integrated with the needs of the people. A child Sonsorship Program was taken for 302 children from poor families. The object of the sponsorship program was to provide all possible facilities for schooling and health care to the children. The families were helped in meeting their felt needs. Over 171 families were given financial support for augmenting their income. 223 such children in Jaipur slums were also provided help. Vocational training in agriculture, livestock management etc. was given. Cross breeding of village cows was arranged. 30 centres for adult education were opened and a camel-borne mobile library organised.

Legal aid was provided to 123 persons - most of them women who were victim of dowry demands and other family discord.

Bal Rashmi organised the community through Mahila Mandals, Youth Forums and Awareness Camps. In 1984 it took up a Rural Health and Training Program for providing immunisation, preventive and curative services and training for grass root-level health workers. Expanded Health Program covering a population of 40,000 in 83 villages of Bassi tehsil was taken up in 1987.

ACTIVITIES THROUGH PVOH GRANT

The project area lies in Bassi tehsil. This is semi arid area with sandy loam soil and having an average rainfall of 22". Communications are poor. Most of the roads are kucha. 53% population comprises of Scheduled Castes and Scheduled Tribes. Density of population is 127 per sq. km. Male to female ratio is 1000:916. Overall literacy rate is 19%. At the beginning of the project estimated infant mortality rate was 136, crude death rate around 15, maternal mortality rate around 5 and crude birth around 35. Only 4% of child population was immunised against deadly diseases.

(Assisted by the U.S.A.I.D.)

BAL RASHMI SOCIETY, JAIPUR
P.V.O.H. PROJECT OF GOI/MOHFW

The objectives of the project were as follows -

(a) immunisation of children against tuberculosis, diptheria, pertussis, tetanus, polio-myelitis and measles.

(b) identifying the under-nourished children and recommending supplementary nutrition.

(c) motivate eligible couples for family planning.

(d) to provide ante-natal, natal, post-natal services to expectant mothers.

(e) create awareness among people by organising health talks, demonstrations, baby shows and film shows.

(f) to provide health and non-formal education to women.

Bal Rashmi opened a Rural Health Centre at Lalgarh which has facility of a 10 bedded - indoor ward, an x-ray machine and a pathological laboratory. There are five sub-centres each manned by a male and a female health worker. The Multi Purpose Workers function at grass-root level, immunise children, take ante-natal services to the pregnant women and deliver health talks. They refer cases to Lalgarh for treatment and identify eligible couples to motivate them for having small families. Records of births, deaths, immunisation etc. are kept to provide definite information about change in various health indicators. People now come of their own for getting preventive and curative health services.

Following is brief description of the work during last three years under this PVO Project :

		1987	1988	1989	Total
1.	3 month training for health guides.	040	021	061	122
2.	1 week traing for health workers.	018	006	009	033
3.	Nutrition Education.	-	052	597	649
4.	cooking demonstration	-	-	332	332
5.	T.T. to mothers	111	376	352	839
6.	Child immunisation				
	- against tuberculosis	413	1272	463	2148
	- against diphtheria	121	1905	889	2915
	- against measles	026	-	905	931
	- against polio	137	1430	899	2466
	- Vit. A Prophylaxis	473	931	1478	2882

(Assisted by the U.S.A.I.D.)

BAL RASHMI SOCIETY, JAIPUR
P.V.O.H. PROJECT OF GOI/MOHFW

NATALCARE	1987	1988	1989	Total
7. Iron Folic Acid Course	333	590	2243	3166
8. Child Delivery by MPHW/ANM	005	113	157	275
9. Home visits for post-natal service	029	331	459	819
CURATIVE SERVICES				
10. Outdoor Patients	2103	3150	3063	8316.
11. Family Planning				
- Condom distribution (No. of men)	080	083	211	374
- oral pill (No. of Women)	015	064	206	2285
- Eye Camps	-	-	004	004
- opthalmic examinations	-	-	284	284
- cataract operations	-	-	052	052

CHANGE IN HEALTH SITUATION

Health care and curative services have been taken to the door-steps of the rural poor. The pregnant women are now cared for and given T.T. injections to curtail maternal mortality and Iron Folic Acid course to correct anaemic conditions. Children are protected against deadly diseases by vaccinating them. Child blindness is prevented by giving them Vit. A Solution. By now all the children living in 54 out of 83 villages have been immunised. Consciousness has been created amongst the people to take up scientific investigation and treatment. Couples are motivated to adopt small families by use of contraceptive devices. A cadre of trained village level volunteers has been created. Training of dais to perform deliveries in an aseptic way has been arranged.

BRIEF ACCOUNT OF ACTIVITIES

Besides these direct health and medical services Bal Rashmi has been creating awareness amongst the people by organising Awareness Camps for rural women, disseminating information about the fatal diseases, rural sanitation, community hygiene, disposal of domestic wastes. 300 sponsored children are taking health care and disease prevention and curative services to their parents and siblings. Bal Rashmi provided the grant and loan on soft terms for augmenting their income. Bal Rashmi conducted a survey of prevalent eye diseases, organised eye surgery camps and undertook 52 cataract operations.

Bal Rashmi had been encouraged by the response from the rural population

in the field of helath and medicare. The society wants to cash on this and continue the program on a long term basis and take up new area for taking training, awareness and disease prevention services to them. The existing infrastructure of the Government health services will be utilised to the maximum for curative services.

IMPORTANT LESSONS

There should be correct identification of the needs and problems of the target population. While formulating the project there was no indication about the widespread opthalmic problems. While working we came across 284 people who were facing eye problems. Formerly there was utter lack of awareness about the health care. The problem was worsened by lack of communication and public transport. Even if somebody got ill he had no means to go to the doctor. This Project created awareness amongst the people and they are now adopting preventive methods to ward off incidence of disease. They now come to their own for getting curative services, vaccination of children and for the care of pregnant women. For an effective health delivery service, the people must get the medicine itself and not just prescription.

Health education has to be an important part of activity of the integrated development program. The village youth, village leaders and schools have to be an integral part of such training program. Community workers should be chosen from the community itself. The success of the program is linked to availability of training and awareness material in the regional language of the area. It can be of use to the grass root level workers as also common people - most of whom are now literate.

ACTIVITIES AFTER 30.09.90

We solicit extension of the Project till 30.09.91 and financial support for the same because resources raised by us have been utilised for construction of the buildings of Rural Health Centre and Sub-centres and other activities. Thereafter Bal Rashmi will run the Project of its own and provide health and medicare service to the people.

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BAM INDIA, CALCUTTA
P.V.O.H. PROJECT OF GOI/MOHFW

1. BRIEF HISTORY OF THE ORGANISATION

BAM India, started as a Partner Organisation of BAM International, an international organisation based in Paris-France in 1965. The activities at that period were mostly of relief in nature during natural calamities and to carry out mid-day school meal programme. In 1977, the organisation got registered and started Health and Development work in various parts of India. In Calcutta, a joint TB and Leprosy Control Programme was launched in the slums of Garden Reach Municipality. Since 1982, BAM India ceased to be a Partner of BAM International. Since then, Mother-Child Health Programme was started in the same slum areas covering the problems of Mal-nutrition, providing immunisation etc. In 1985, a comprehensive Mother-Child Health Project under PVOH-I Scheme has been started along with the existing TB, Leprosy Programme.

IIa. ACTIVITIES AND THE AREA

The comprehensive Mother-Child Health Project was undertaken under PVOH Scheme covers a population of nearly 28,000 in the slum area of Garden Reach. Garden Reach is an industrial belt. The high density of population (17,000/Sq.Km.). The population is mostly Muslim(70%). Poor Sanitary and Environmental condition, lack of health facilities results abnormally high prevalence of communicable diseases. Frequent pregnancies, non-acceptance of Family Welfare Services, low level of literacy and ignorance has been causing high Infant Mortality (110/1000) and high Maternal Morbidity. In a base line survey of 1985, it was seen :-

* 65% Children were mal-nourished
* 18% Children were immunised
* 90% Deliveries were conducted by untrained T.B.A.
* I.M.R. was as high as 110/1000

The activities framed with an objective to :-

* Immunise 80% of children against Tetanus, Dipthoria, Whooping cough, Polio, Measles etc.
* To improve nutritional status through nutrition education, cooking demonstration etc.
* To make the mother aware on health problem by extensive Health Education
* To set up low cost curative centres for under six children
* To provide Family Welfare Services
* To promote institutional delivery
* Training of Traditional Birth Attendents
* Training of 4 local slum mother as Community Mother

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(Assisted by the U.S.A.I.D.)

BAM INDIA, CALCUTTA
P.V.O.H. PROJECT OF GOI/MOHFW

Three sub-centres were opened in 3 wards of the Project Area. In this sub-centres Curative Clinic, Immunisation Clinic, F.P. Antenatal Clinics, Nutrition Clinic, Group Meeting are being carried out. Apart from that door to door survey, coverage are also being done for Immunisation, Nutrition Education, F.P. Counselling etc. at the door steps. One 8 beded Maternity Centre was opened at the Head Quarter (within the Project Area) where an O.P.D. functions for Mother and Children.

IIb. DATA INDICATING CHANGES IN HEALTH INDICATORS SINCE THE START OF THE PROJECT

O	In 1985	In 1990
* Coverage of Immunisation by TA, DA, Polio Vaccine	18%	88%
* Nutritional Status		
1st degree	30%	25%
2nd degree	23%	9%
3rd degree	12%	6%
* Antenatal coverage Less than	10%	80%
* Couple protection rate Less than	5%	46%
* I.M.R.	110/1000 live birth	Not available(but certainly came down)
* Practice of O.R.S.	Nil	70%

Some of the achievements are not possible to reflect in figure like the weaning food habit. In this area particularly among the Muslim Group, this was not practiced at all but after all efforts on nutrition education many of them started to give semi-solid food but not before 6 months. The use of tinned milk also avoided by many families. ORS is being practised extensively in the community.

III. ACHIEVEMENTS AND FUTURE PLANS

BAM India is running a Leprosy Eradication Project which covers a population of nearly 7,50,000. In Garden Reach Area, M.D.T. has been successfully launched and prevalence came down from 13/1000 to 3/1000. Side by side the infectivity load of the community, the deformity rate (from 20% to 2%) also came down. Health Education resulted high attendence, regular drug intake and removal of the stigma about the disease. Local School Children of higher classes, volunteered to detect cases, local Youth Club where we run our clinics Co-operate in tracing defaulter cases. This programme is supported by Govt. of India and German Leprosy Relief Association. The TB Programme so far

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treated more than 3500 TB cases and cured nearly 2200 cases. The same team works both for Leprosy and TB. We have 17 treatment centres for TB/Leprosy treatment along with Physiotherapy, Dressing etc.

The Leprosy Programme which made successful intervention controlling Leprosy in Garden Reach, has been extended to newer areas and will continue with the support from Govt. of India and German Leprosy Relief Association. TB drugs are also supplied by Govt. of India and TB Control Programme will also be continued along with Leprosy activities.

Few of the achievements of PVOH Project has already mentioned in IIb. column. This project will face termination of Govt. Financial support after Sept. 1990. We foresee the Community Mother will be there to continue the work as much as possible and the Maternity Ward, with some subsided charge taken from the patients, to run in a Non-profit making way. But in a city like Calcutta, it will be certainly difficult to pay the ren of the buildings and salary of the Professional. However, the local collection for last few years was going up giving us the hope to continue our activities at a minimum level.

The experience, we gathered during this period of PVOH Project is in-valuable. We would be very happy to use this rich experience in newer areas preferably in Rural Areas may be under PVOH-II.

IVa. IMPORTANT LESSIONS LEARNT FROM THEIR ACTIVITIES

Community participation is almost inevitable for any health development activities.

Grass-root level workers are the key person of any community development.

Staff of all levels should be involved in decision making within Voluntary Organisation.

Objectives or goals to be framed before starting any activity and the methodology to reach the objectives have to be revised depending on the situation prevailing at any point of time.

The gap between Ministry and Voluntary Organisation can be minimised effectively by presence of Institute like National Institute of Health and Family Welfare(NIHFW).

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BAM INDIA, CALCUTTA
P.V.O.H. PROJECT OF GOI/MOHFW

IVb. PLANS OF THE ORGANISATION TO SUSTAIN ACTIVITIES NOW BEING CARRIED OUT UNDER PVOH GRANT AFTER SEPT.1990

Already mentioned in IVa.

DR. P.K. MITRA
Secretary
BAM INDIA, Calcutta

BARODA CITIZENS COUNCIL
P.V.O.H. PROJECT OF GOI/MOHFW

A bit of History

In 1964, American Friends Service Committee (Quaker's Group) decided to start a pilot project of five years duration in Urban Community Development in India. They surveyed 119 cities in the country and finally chose Baroda. One major reason which titled their decision in favour of Baroda was the readiness shown by the three leading institutions of the city namely Baroda Municipal Corporation, Federation of Gujarat Mills & Industries and Maharaja Sayajirao University of Baroda to ensure the continuation of the project after the withdrawal of American Friends Service Committee. Subsequently, the need for an advisory body of citizens became instrumental to the formation of Baroda Citizens Council.

Over the years, the Council has developed into a unique institution and is a premier professionally managed community development organisation in the country. It has adopted the philosophy of organising people to take control over their own lives with integrated community development approach covering health, education, economic, housing and awareness inputs. At any given time, the Council is engaged in community development work with about 10,000 families from lower socio-economic groups. It has also implemented projects at the macro level e.g. leprosy control program, city-wide immunisation program, identification and rehabilitation of disabled children in all the slums of Baroda, children in difficult circumstances, day care centres for senior citizens, low cost housing, counselling centre for young persons etc. In the year1985, the Council started a centre for non-profit organisations (non-governmental agencies) which gradually culminated into "United Way of Baroda", the first of its kind in the country. The main objective of this intermediate body is to strengthen the voluntary sector in Baroda through the process of need-based funds, pooled supportive services, dissemination of useful information and management assistance.

*Profile of Community under PVOH-1 grant

Unreached or under-reached urban slum areas having scanty health and education services. (49 pockets made into 10 manageable units). No. of families - 5,800, Population - 26,529, Female - 47.60%, Male - 52.40%, Size of the Family - 4.6.

Break up of Population

Children (0-6 years) - 17.41%, Adolescents (7-15 years) - 26.35%, Adults (16-44) - 23.32%, Female (Above 44) - 3.50%, Male (16-44) - 25.28%, Above 44 - 4.11%.

Literacy Rate

Secondary and above - 29.68%, Primary (1-7) - 55.71%, Illiterate - 14.60%.

(Assisted by the U.S.A.I.D.)

BARODA CITIZENS COUNCIL
P.V.O.H. PROJECT OF GOI/MOHFW

Employment/Occupation (Male)

Organised Sector - 58.64%, Unorganised Sector - 39.58%, Unemployed - 1.67%, Retired - 0.11%.

Female

Organised - 2.07%, Unorganised - 7.47%, Housewives - 90.56%.

Sanitation

66.19% of the families had no toilet and drainage facilities.

* During July-December, 1989.

Description of activities done through the PVOH grant

(a) Preventive : Vaccination including measles, Pre and Post-natal care including Registration, check up, T.T., hospitalised deliveries, referrals, Iron and Vitamin A Prophylaxis.
(b) Promotive : Health Education, Family Planning, Sanitation e.g. toilets, soakpits, drainage, water pumps.
(c) Curative : Clinics, Supplementary Feeding Program (Upto 30.9.89).

Changes in Health indicators

	Beginning of the Project	End of the Project
Vaccination		
Primary		
BCG	79%	95.4%
Triple & Polio	60%	87.2%
Measles	32%	93%
Secondary		
Triple-Polio	36%	81.5%
Booster II	49%	83.2%
TT (for pregnant women)	13.3%	94% (1st doze
	9.6%	99% (2nd doze)
Infant mortality	80%	60¢
Home deliveries	37.1%	10.9%
Pregnant mothers receiving ante-natal care	15%	95%
Effective couple protection rate	42.5%	58.6%
Family size	5.3	4.5
Toilet, drainage & water facilities	23.7%	35.6%
Babies with birth weight below 2500 gms.	10%	4%

BARODA CITIZENS COUNCIL
P.V.O.H. PROJECT OF GOI/MOHFW

Note : In addition to the above achievements, a city-wide immunisation program was organised in 1986.

Present Activities other than under PVOH-1 project

Research-cum-service project on women's reproductive health care covering 1,363 families. Special stress is on Anemia, Leucorrhoea, infertility and Menstrual disorders.

Rehabilitation of 3,000 children in difficult circumstances (disabled, child-labour, orphans, destitute and drop-outs).

Low Cost Housing for slum dwellers on repayment basis, shelter improvement of the existing ones, construction of community centres with participation of beneficiaries, material bank and training in construction skills.

A city-wide Baroda Community revitalisation project covering needs assessment, Resource Mobilisation, computerised socio-economic data bank and leadership development.

A city-wide "United Way" movement, wherein local community resources are mobilised and given to smaller voluntary organisations. In addition to this,common supportive services, training, management assistance is provided.

Research, Training and Publications : The above activities are carried out to reflect on the urban issues. Publications : Voluntary Scheme in Baroda, Financial Assistance available to NGOs., Public Trusts in Baroda, City-wide Immunisation Program in Baroda, Baroda Fights Childhood Disabilities, Guide for Community Leaders, Application of Social Research in Development Projects, Life in Baroda in the 90's and Baroda Community needs.

Future Thrust Areas : Under-employment and unemployment, Female literacy, Housing, Health Family Planning and Sanitation, Childhood Disability.

Important Lessons Learnt : Gained intimate knowledge and first-hand experiences about community health and the operating services. This has increased our organisational capabilities in the health sector.

Improvement in selected health issues can be achieved by simple and sustained methods.

Health is an integral part of community development but not the end by itself.

BARODA CITIZENS COUNCIL
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Supplementary nutrition, morbidity, health education are comples phenomenon.

80% of urban slum dwellers have capacity to pay at least 20% cost of any service. However, to expect them and implementing organisation to mobilise 100% of the cost is a myth.

Plans of the organisation to sustain activities now being carried out under PVOH grant after September 30, 1990.

Short term : 50% from local resources (20% from beneficiaries and 30% from City population).

50% matching grant from USAID or any other funding agency.

Long Term : Health post under Government of India's urban revamping program.

Note : Besides the activities mentioned on page 3, the Council at any given time is engaged in community development program with about 5,000 families covering economic, education, health, sanitation and development of local leadership inputs. The major activities under each non-health inputs are given below :

Economic : Skill Trainng for underemployed or unemployed youth, Savings and loans Associations, income generation activities for women, procurement of ration card, loans and subsidies for self-employment.

Education : Pre-schooling Program, coaching classes, school admissions, school readiness program, recreation centres.

Leadership : Awareness camps, support to voluntary groups in the community and helping them in resolving community issues.

BHARATIYA GRAMEEN MAHILA SANGH
P.V.O.H. PROJECT OF GOI/MOHFW

A **A BRIEF HISTORY OF ORGANIZATION:** Bhartiya Grameen Mahila Sangh is a constituent unit of ACWW. Its Madhya Pradesh branch came into existence in 1960 starting with 5 members. Since last 30 yrs. Bhartiya Grameen Mahila Sangh, M.P. Is working for welfare of rural women & children through literacy, income generating activities, health activities & awareness generation. The main objective of organization is to generate the organisational & leadership abilities in rural women & to bring about social & political awakening in them by forming MAHILA SAMITI, & MAHILA MANDAL at District, Block & Village levels. We have been doing intensive & concentrated work among rural men & women with a view to step up their status & secure better conditions to meet their immediate educational, health & social & economical needs towards the attainment of better standard of living. The main Projects presently being run are (1) STATE RESOURCE CENTRE FOR ADULT EDUCATION (2) CHRISTIAN CHILDREN'S FUND INC., (3) JEEVAN JYOTI HEALTH EDUCATION CUM SERVICE PROJECT (4) ADULT LITERACY PROGRAMME UNDER WHICH 600 ADULT EDUCATION CENTRES ARE BEING RUN (5) CRECHES, BALWADIS, VOCATIONAL TRAINING, HIGHER SECONDARY SCHOOL FOR RURAL GIRLS, INCOME GENERATING, PROGRAMMES, TRAINING IN AGRICULTURE & ANIMAL HUSBANDARY ETC.

IIa. **DESCRIPTION OF ACTIVITIES UNDERTAKEN UNDER HEALTH**

PROJECT : The Project was sanctioned on 29th Nov.'83 & we actually started functioning from 1-1-84. Our main strategy was to make rural women as the main media to bring about an improvement in the health status of rural poor. Bhartiya Grameen Mahila Sangh has a Rural Community Development Centre at Village Rau situated 15 kms. from Indore. Rau was selected as a pivot around which all the health activities could revolve. 40 villages around Indore were selected. These villages are situated in unreached, under developed and far flung areas not having, medical facility for immunization, safe delivery etc. Most of the village folk in these villages are marginal farmers or landless labourers living below the poverty line and mostly belonging to tribal & backward classes. The villages are connected by fair weather roads. Total population of these 40 villages is 50,000.

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ACTIVITIES: Bhartiya Grameen Mahila Sangh completed the establishment of infrastructure in first 6 months of starting the project which included (i) Starting of 16 beded hospital at Rau OPD, O.T. block & a nutrition demonstration centre (ii) Establishment of 8 sub-centres (iii) Base line survey (iv) Recruitment of staff (v) Starting of mobile services. Project worked on a 3 tier system. At the grass root level were 40 female village health guides, who are our strongest link in the 3 tier system. On cluster of 5 villages a sub health post was established having 3 maternity beds with a staff of 1 ANM, 1 Ayah and 1 helper. 8 such health posts were established. The main health centre at Rau worked as referal centre with facilities of minor & major operations, specialists services, indoor services, cancer detection centre, pathology lab. Immunization, MCH services, health education & treatment of common ailments was done through a mobile van, which visits two villages per day.

IIb. ACHIEVEMENTS OF THE PROJECT : In its limited budget the organisation carried out its activities in a very cost effective manner. In terms of numbers the following statistics reveal the achievements of the project.

S.No.	Type of Service	Target	Achieved
A.	**ANTENATAL CARE:**		
1.	Registration of Ante Natal care	6,000	6,181
2.	Total number of contacts	18.000	12,389
B.	**NATAL CARE:**		
1.	Deliveries conducted by Project Hospital/Staff	2,000	1,546
2.	Home deliveries conducted by the Project.	3,000	1,688
3.	**POST NATAL CARE:**	8,500	8,228
	IMMUNIZATION		
	Mother T.T.	8,000	15,144
	Children		

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	BCG	8,400	9,548
	DPT	8,000	6,621
	POLIO 3 DOSES	8,000	7,087
	Measles	3,000	3,965
	HEALTH EDUCATION :		
1.	Group meeting	1,230	3,345
2.	Mass meeting	500	1,806
3.	Individual contact	7,200	16,387
4.	Exhibition	17	62
5.	Film Shows	43	85
6.	Orientation Camps	16	15
7.	Cooking Demonstration	105	100
8.	Health Mela (fair)	-	-

The organization has been able to achieve a positive change in the attitude of the rural masses towards immunization, antenal, postnatal care, personal & environmental sanitation, hygiene & adoption of family planning.

IIIa **INNOVATIONS & HIGHLIGHTS :** The Project has tried some innovations like linking HEALTH ACTIVITIES WITH NON FORMAL EDUCATION & income generations etc. Further experiment of organising HEALTH MELA (HEALTH FAIR), MAHILA MANDAL, NAV YUWATI MANDAL AND SCHOOL HEALTH CLUB has been very fruitful.

(b) **PREVENTION OF CANCER:** Bhartiya Grameen Mahila Sangh has trained 40 VHGs for early detection of oral & cervical cancers. Education of masses for prevention of their cancer has been taken up.

(c) **EYE CARE:** Bhartiya Grameen Mahila Sangh has successfully operated 1000 cases for cataract & glaucoma. Spectacles for various refractive errors have also been given. Thus in its 40 villages preventable blindness has been fully curbed.

(d) **DEVELOPMENT OF HEALTH EDUCATION MATERIAL:** Bhartiya Grameen Mahila Sangh has published 15 books on Health education in addition to pamphlets, posters films for rural masses.

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(e) **POPULARISATION OF SOYABEAN:** Soyabean is the Indian meat with very high protein content. Soya milk & various recipies of soyabean were popularised by means of nutrition demonstration.

(f) **POPULATION EDUCATION CAMP:** A new concept of family welfare was given by organisation of population education camps for young married couples in which the whole concept of small family norm was given by lectures, exhibitions, group discussion & individual problem solving.

(g) **LEADERSHIP DEVELOPMENT FOR HEALTH FOR ALL:** Leadership Development for HFA was put into practice by organising workshops & lectures.

(h) **INTEGRATION WITH ADULT EDUCATION:** The village health guide acting as an adult education instructor created a close rapport with community & this brought down the dropout rate in vaccination programme & better acceptance of family welfare.

IVa. IMPORTANT LESSONS LEARNT:

(1) Women are the best media to bring about a positive change in health status of rural community. The workers at grass root level must be made the strongest link of health care delivery system & he/she must belong to the same village.

(2) Intra & Inter sectorial cooperation, horizantal & vertical integration of activities give best results.

(3) Close emotional contact with the community & community participation by Mahila Mandals, Village health committees, Yuvak Mandals give best results.

IVb: SUSTAINING OF ACTIVITIES AFTER 30TH SEPT. 1990: some of our activities can be sustained by Bhartiya Grameen Mahila Sangh itself. Further, help from other social welfare organisations such as Rotary club, Lions, Jaycees, etc. can be taken. A few volunteers have been identified and trained to give honorary services. In a few villages the community has come forward to maintain the sub health post. The dream of self reliance is still far off, but let us be encouraged by our achievements & take a lesson from our failures & join hands to achieve "health for all by 2000 A D".

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CHILD IN NEED INSTITUTE, W.BENGAL
P.V.O.H. PROJECT OF GOI/MOHFW

1. **History**

CINI-Child In Need Institute was set up in 1975 in a village near Calcutta to provide health services to children in the area. Although the initial approach was relief and welfare oriented, it was not long before it was realised that a predominantly curative approach could make little if any impact on the overall health status of the child population. The women, in her role as the mother of the child, was recognised to be a vital unit in the community. The shift to a community based preventive and promotive system of health care was accompanied by a movement to organise women's groups (Mahila Mondals) in each village in the Institute's area of operations. These groups now function as the cutting edge of our effort to develop a comprehensive and holistic health programme. In a logival extension of this line of thought, the need for imparting specil skills to the mother led to the organisation's involvement in a wide range for training activities for community and village level workers as well as training programmes for workers in various governmental and non-governmental community health and social welfare programmes. The Institute's research unit also evolved as a response to the need for integrating new concepts with the experience of our work in the filed. Today, CINI has moved from being purely a service organisation to one which provides support to various grass-root level initiatives. Over the last decade the Institute has also built up a multidisciplinary team of professionals and community level workers in keeping with constantly broadening perspectives of development.

2. **PVOH Activities / Achievements / Highlights**

CINI took up this project in 1984 in 40 villages with a total population of about 73,000 in about 12,000 households. The broad long term objectives were to bring about improvement in the nutritional and health status of children and pregnant and lactating mothers, to increase access to and adoption of family spacing methods, to provide health education to the community and improve the level of home and community situation and to train various level of personnel in preventive health care. At the micro level these objectives were translated into the establishment of community level health care and immunization services, rehabilitation of severely malnourished children, establishment of growth monitoring systems and conducting training programmes for health care personnel operating at the village level. Towards achieving these objectives, CINI provides services through its children's hospital and NRC which in turn provide support to a network of health posts at the community level and to women health workers at the family level.

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CINI runs an under-five clinic on the campus which provides a range of preventive, promotive and curative services to mothers and their under-five children. Once a week, this clinic caters to all comers on the cafeteria system with immunization, growth monitoring , iron, folic acid and Vit.A supplementaion, antenatal check-up and treatment of illnesses and malnutrition. Severely ill children are admitted to our Emergency Ward and Nutrition Rehabiliation Centre. This weekly clinic is attended by mothers and children from villages far outside our immediate area of operations. On the other six days of the week, the clinic handles cases referred by village health posts or by our village level health workers who are themselves members of village level women's groups who makes regular visits to every home in the village. A mother with a sick child will first be referred to our clinic and later, if necessary, to a teaching hospital in the city. Community awareness on health and involvement in health care has thus been mobilised to the extent where the acces to health services is practically universal.

In keeping with the basic idea of health as a people's issue, and as something wider than mere health care, a large part of our activities under the PVOH Project fall in the area of training. The effort has been to involve all members of the village community, with the women as the vanguard and to create a body of knowledge regarding preventive and promotive health care and child survival strategies. Young persons, village opinion leaders and panchayat officials and members of women's groups have been participants in training programme on child health, community health, environmental awareness and sanitation and so on. Practitioners of traditional systems of medicine as well as dais or traditional birth attendants and village quack doctors have been trained in basic health care. The success of these efforts is reflected in changes in health indicators in the community during the period 1985-1900 (see Table - 1).

Table-1 : Changes in selected health indicators in the project area, 1985 - 1990.

	1985	1990
1. Antenatal Care :		
- Registration of antenatal cases	28.0%	89.6%
- Number of Home deliveries performed by Trained Dais	0	55.0%
- Tetanus Toxoid coverage of pregnant mothers	28.0%	83.3%

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2. Immunization of 0-5 yrs. old children	1985	1990
- B. C. G	52.0%	93.1%
D P T (3 doses)	35.0%	80.0%
- Polio (3 doses)	34.9%	75.0%
- Measles	—	98.5%

3. Family Planning

Methods used by practising couples		
Tubectomy	15.4%	37.0%
Vasectomy	3.7%	1.7%
Condom	0.3%	4.0%
Pill	3.7%	18.5%
I U D	0.1%	8.7%
Natural methods	1.1%	24.3%
Homeopathy	—	5.8%

Away from the purely "health" focus the organisation has helped community women s groups to become involved in a range of income generation activities and provides marketing and technical support The idea is to strengthen the economic base of the family and the community as a part of the overall strategy to raise their health status. Child sponsorship programme have also been taken up as a part of this effort.

3. Strategies for the future

Over the years, we have realised that our focus on the woman solely in her role as child-bearer and rearer is both unjust and inadequate. Our services for women which started off as ancillaries to our child care services, have so far been confined to an antenatal clinic and family spacing unit. We plan to extend our involvement both with women's health and social empowerment of women. A pilot project on the girl child is an attempt to make them aware of their status in the community as a first step towards organising to demand empowerment. Another significant lesson has been the realisation that village level women s group should be partners in every stage of our activities, from planning to implementation instead of being brought into implement preconceived programme.

Another significant gap, also growing out of our perception of the mother as the only person responsible for the child's health, is the exclusion of the father. We now plan to remedy this lack by focussing on both parents as equally responsible for and involved in child health care.

CINI has been functioning as a source of technical and organisational support to a number of newer voluntary groups working in similar or related fields. These include groups working in the broad area of community and maternal and child health in rural Bengal, groups working with disabled children and street children and groups whose focus is on training of grass-root level workers.

Our focus in the post-PVOH phase will therefore continue to be on an integrated community based preventive and promotive health care programme where women and their organisations are the vital determinates of the community's health status. We however, are still exploring different strategies for integrating the men in our work.

4. Sustainability

To sustain, strengthen ad widen the scope of various activities being carried out under the PVOH Scheme CINI has formed a cell to organise fund raising activities. This cell has already initiated some and have plans to start some other programmes for fund raising. These include tapping individual and corporate sector donors, organising periodic events like sponsored **"Walk for the Child"** concerts, art exhibition etc. Besides these, the Institution is also exploring various other foreign and domestic funding sources for the sustainance of this programme.

CHINMAYA TAPOVAN TRUST, KANGRA
P.V.O.H. PROJECT OF GOI/MOHFW

A. INTRODUCTION:

The CHINMAYA RURAL PRIMARY HEALTH CARE & TRAINING CENTRE was inaugurated by H H Swami Chinmayananda in April 1985 when it came into being under the USAID funded PVOH-scheme of Ministry of Health & Family Welfare, New Delhi. It is situated in Kangra Distt.Himachal Pradesh in the laps of the Himalayas near Dharamshala. The villages served by it in this area are in difficult terrain and are often inaccessible by road. Other factors like scattered and scantily spread population, difficult communication, unpredictible heavy rainfalls, peculiar to this region, make delivery of primary health services in the community a challenging job.

The CHINMAYA RURAL PRIMARY HEALTH CARE & TRAINING CENTRE, is a community health offshoot of CHINMAYA TAPOVAN TRUST, Sidhabari. The main objective of the Trust is to promote universal brotherhood through its inspired training of students in Vedanta and propagation of the spiritual wisdom of India. Its other objectives are to uplift and help the people through its various programmes like old age homes, schools, and running a special school called Hari Har School (which is a free, vocational and academic school with nutritional care of the children benefitting the poorest of the poor village children) and running various programmes in a holistic approach to health through the Chinmaya Rural Primary Health Care & Training Centre.

B. ACTIVITIES:

The three main components of the Centre's activities are:

1) TRAINING OF peripheral health workers.
2) PRIMARY HEALTH SERVICES with special emphasis on maternal and child health through a central referal OPD and subcentres in the village.
3) AWARENESS PROGRAMMES in the community.

C. BACKGROUND, CHANGES & POTENTIALS:

Presently, the training centre is training the third batch of Multipurpose Workers(F). Each batch comprises of 30 trainees. The course is recognised by the Nursing Council of Himachal Pradesh and the students are examined by the same council. The last batch did very well. Out of thirty

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trainees, twenty nine of them passed with distinctions, bringing unprecedent glory to their training centre. Some of the MPW(F)s who have been trained by us are now serving the subcentres and villages under the project. With their remarkable work they have demonstrated that properly trained and supported MPW(F)s can definitely form a strong base for primary health care in India and strengthen to a great extent the main professional link of reaching out health care to the people. The village health guides and traiditional birth attendants trained by us under the project and now serving the villages in co-ordination with us have also proved their credibility and utility in their villages. The three components of our work comprising of TRAINING, PRIMARY HEALTH SERVICES & AWARENESS PROGRAMMES are so interlinked and interwoven that each one serves to strengthen the other. The three dimensional approach has increased interaction with the community with their better participation in the programmes and made the training realistic by providing a dynamic field for training. The good response of the people to our health programme is demonstrated by the marked improvement in the various indicators of health since our base line survey in 1985. For example 'Kund', a remote village subcentre has now a 100% coverage of immunisation amongst the children whereas five years ago the figures for 3rd dose of DPT and Polio were 2.2% and 0.7% respectively with none of the children having ever received a booster dose of either.

Our field work and training programmes, attracted the attention of some voluntary organisations in the State and neighbouring States and some of them have deputed their community workers for short term training courses. Also, through the Himachal Pradesh Voluntary Health Association in co-ordination with the Voluntary Health Association of India, New Delhi, we have trained Balsevikas of Himachal Pradesh Voluntary Organisation working in their creches. Our pilot project on this has led us to understand the gaps and the needs of creches (Balwadis) better and we thus try to improve our training sessions in an attempt to fulfill these gaps and schedule our training to the learning needs of the Balsevikas.

As we worked in this area in close association with the

people for health another important factor become apparent and demanded attention. The vicious cycle of increasing work load of rural women (as more and more men take up jobs, leaving the agriculture responsibility entirely to the women) their illiteracy, dependency, isolation, the unknown and unrecognised contribution of their labour towards the economy; the low image of village women, their marginalisation from society with the usual food, water and sanitation problems that go with poverty and ignorance began to hit one as the not so apparent but important bases of continued ill health of women and consequently of families. Besides, there is no doubt about the fact that a mother is the most important primary health worker. It thus became apparent to us in the project that unless the local women themselves became agents of change, programmes meant to improve her lot could threaten to make her more dependent and less self-reliant. With this background, we began to work intensely with women groups. Two of our village health workers, both village women with primary school education only, began to show potentials as good organisers of women with the ability to express themselves clearly and confidently about issues related to women regarding health or otherwise. Thus we promoted them as co-ordinators of Mahila Mandals and they have established 30 mahila mandals in the villages so far by their own efforts. What is most commendable about these mahila mandals is that they are being co-ordinated by two simple local village women, and that they are run entirely by the village women themselves who regularly hold meetings,record the minutes of their meeting and implement some of their issues and follow it up in the next meeting.

Working in the villages, the fact that health cannot be isolated from our lives stares loudly at anyone and the need to create awareness in the people to become responsible towards maintaining and promoting health, preventing ill health as 'their need', as against regarding health only as medicines and injections when illness stops them from their work has to be discussed repeatedly with them till they understand it, take steps to improve it and mobilise the existing and often dormant resources to come out of the vicious cycle of ill health and poverty. Thus we are

gradually intensifying our interactions with the community through various modes of entry such as youth clubs, balvihars, schools, panchayats, balsevikas, govt.health workers, school teachers mixed village groups besides the mahila mandals mentioned earlier. In our attempt to create active participation of the community we began to interlink our peripheral visits with inviting various groups for a whole day with us for discussions and learnings. Thus now, besides, training health workers, we have entered into building up AWARENESS amongst the people.

D. FUTURE PROSPECTS:

The long term benefits of the programme that we envisage is this mobilisation of the human resources lying dormant now and making maximum utilisation of the resources and infrastructure already available with the people at various points in departments interelated to health as health cannot be isolated from the various aspects that influence our life. Besides, such a holistic approach to health will provide training to the various levels of peripheral health functionaries in a realistic field base where the vibrant background of services and awareness programmes will be fulfilling a very big gap, often seen in the training programmes of peripheral health workers. This type of training will thus produce workers in the field with greater potential of delivering integrated community services, so essentially required for making health, a reality to the majority of our people. We are hopeful that we might be able to sustain the training with the help of Ford Foundation with whom we are negotiating presently for the next two years and later, something substantial for MPW (F) training will come through the State or Central Govt. in the future when our potential for training peripheral health workers in a reality base situation is realised.

GURU CO-OP. MILK UNION, BHATINDA
P.V.O.H. PROJECT OF GOI/MOHFW

INTRODUCTION

The Bathinda District Cooperative Milk Producers' Union Ltd is operating a Rural Health Project named "Operation Concern" in the villages of district Bathinda. In this regard, The Bathinda District Cooperative Milk Producers' Union Limited is functioning as a Private Voluntary Organis-ation for health. The Govt. of India, Ministry of Health & Family Welfare has sanctioned this project. The project was spread over a period of four years from 1 April, 1985 to 31 March, 1989 and was further extended upto 30 Sep.'90.

BATHINDA MILK UNION

The implementation of the health project rests very heavily on the Milk Cooperative infrastructure. Therefore, it is necessary to outline the relevant portion of this infrastructure. In Bathinda district, the Milk Union was formed in 1978 but became operational on 1.3.1980. So far, the union has organised 395 milk producers' cooperative societies with a membership 33,062, 40 societies have purchased Milko-Testers from the Union. Veterinary services are being provided by the union to the villagers and FMD vaccine was also administered to animals.

In Bathinda district the majority of the farmers are illiterate Exploitation by private medical practioners (most of whom are not even qualified doctors) is quite a severe problem. A small remedial step in this direction, project "Operation Concern" being implemented in 153 elected villages of this district.

BEGINNING OF THE HEALTH PROJECT

Realising the great potential offered by such a network to improve the health of the rural folk by taking comprehensive health care services to the door steps of the community, the Bathinda Milk Union started a Pilot Project in February, 1983. This project was funded and monitored by the Family Planning Foundation with the assistance of the National Dairy Development Board. An appraisal team detailed by the Govt. of India, Ministry of Health & Family Welfare observed the functioning of the Pilot Project and felt satisfied with its working and therefore, recommended the approval of the present project.

(Assisted by the U.S.A.I.D.)

GURU CO-OP. MILK UNION, BHATINDA
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SCOPE OF THE PROJECT

The project proposes to provide simple basic health services, with particular emphasis on maternal and child health and Family Planning promotion through spacing methods, at the door steps of the community. This work is linked with PHCs and district hospital through a referral system.

METHODOLOGY

(a) The Milk Producers' Cooperative Societies in the main villages call meeting of the entire village and make out a resolution declaring their willingness to adopt the health scheme.

(b) In each of these village, there are two health workers, the dairy coop Secretary is the male health worker and the traditional 'dai' is the female health worker. These health workers have been trained for a period of 15 days prior to the launching the project. Monthly they attend a training/discussion session at the Milk Plant. The male health work is paid a honorarium of Rs. 50/- per month and the female health worker Rs. 100/- per month.

(c) For the purpose of simple curative services and continuous education of the village health worker, fortnightly clinics are held on fixed days and times by visiting A.N.M.

(d) Mobile Teams composed of three A.N.Ms. leave together in one vehicle starting from Health-cum-Training Centre at Milk Plant and return after completion of the day's programme. Each team is required to visit 18 villages per week i.e. 3 villages per day.

(e) Drugs and dressings for the curative work are purchased at Bathinda at whole-sale rates. They are distributed to the patients on no profit no loss basis.

(f) Referral arrangements have been made with Govt. PHCs and District Hospital.

(g) A small Health-cum-Training Centre has been constructed at Milk Plant, Bathinda. Besides the training of village health

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GURU CO-OP. MILK UNION, BHATINDA
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workers, this centre will provide special care and education for rehablitation of acutely malnurished mothers and children.

(h) Family folder system as devised by Department of Community Health of Christian Medical College, Ludhiana has been adopted.

The following action items are covered under the programme:

1. CURATIVE SERVICES: (a) To provide the services of qualified ANMs. at the door step of village community, where curative aspect of health is taken care of at nominal cost.

(b) Provision of referral services for patients requiring specialised treatment. To enable this, liaison has been established with existing government medical infrastructure in the area.

2. PREVENTIVE AND PROMOTIVE SERVICES:

(a) Monthly check up of expectant mothers to ensure a safe delivery and early identification of high risk cases so that necessary action can be taken in time.

(b) Administering tetanus toxide vaccin to pregnant mothers alongwith Fersolate tablets, Vitamin A Syrup etc.

(c) Education on importance of nutrition and personal hygiene of mothers.

(d) Immunisation of all pre-school and school going children.

(e) A.N.Ms. to run the under five clinic to assess the growth & development of under five children by maintenance monthly weight and arm circumference records.

(f) Vitamin A syrup to be given to under five children at a interval of six months to protect them against night blindness

(g) Oral re-hydration cases to be treated by the village health workers/A.N.Ms.

(h) Motivation necessary guidance and requisite services are provided to eligible couples desiring to plan their families.

(i) Since the incidence of drug addiction is very high, sufficiently motivated farmers are to be helped to get rid of their addiction problems.

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(j) Buffalo loan to be arranged for eligible candidates in co-ordination with the local rural development agency, so as to help the family in becoming economically self sufficient.

3. Environmental and Sanitation:

(a) Digging up of soakage pits for disposal of waste water.

(b) Installation of smokeless chullahs for reducing the probabilities of visual disorders amongst rural women folk.

(c) Encourage of use of Bio-Gas.

The organisation learnt from this activity that people could think health services are their own services, involve the co-operative infrastructure in a wider participation for social change in its villages through such efforts for better health and small family norms and . . demonstrate that the involvement of co-operative . .structure in human health is beneficial to their own operation.

The matter for further planning after 30th Sep '90 has already been put in the meeting of Board of Directors. The decission taken by the B.O.Ds. will be followed accordingly.

KAMALA NEHRU HOSP., ALLAHABAD
P.V.O.H. PROJECT OF GOI/MOHFW

I **BRIEF HISTORY OF THE ORGANISATION** :

Great humanist and Freedom fighter Smt. Kamala Nehru converted some rooms in Swaraj Bhawan, into a Hospital, with a ward and an operation theatre in 1931. After her death, to realize her ambition to work for underprivileged women and children, Mahatma Gandhi himself campaigned for funds and laid the foundation stone of the Hospital on Nov. 19, 1939. Bapu himself inaugurated the Hospital on Feb. 28, 1941.

Kamala Nehru Memorial Hospital Trust which controls the Hospital was registered under the Registration of Societies Act (1860) in Sept. 1937 with a Board of Trustees.

Major events in the history of orgnisation are given below :

a) 1943- Recognised as a training centre for Midwifery candidates by the U.P. State Medical Faculty.
b) 1946- Antenatal Clinic started.
c) 1947- Pathology department started.
d) 1949- Opening of an OPD named after Begum Abul Kalam Azad.
e) 1959- Formal inaugural of a well equipped Cancer Wing.
f) 1964- Affiliated to M.L.N. Medical College,Allahabad to provide teaching and Clinical facilities in O&G for undergraduate and postgraduate students.
g) 1971- Participation in the Post Partum Programme of the Govt. of India.
h) 1984- Installation of Janus-60 Cobalt unit for Radiotherapy treatment of Cancer patients, re-establishment of Cancer Wards.
i) 1987- Installation of Theratron 780 C.
j) 1987- Installation of Selectron LDR.
k) 1987- A PVOH Project entitled "Accelerated Primary Health Care to Improve Maternal and Child Health at Grass Root Level"undertaken.
l) 1988- Installation of RT-3000 Ultrasonography.
m) 1988- Kamala Nehru Gramin Hospital(Rural Health Centre) constructed. Initially working in rented building,since 1987 started functioning from constructed building.
n) 1989- Construction of 30 bedded ward at Kamala Nehru Memorial Hospital during 1988-89.
o) 1989- Installation of CT Scan.

IIa **DESCRIPTION OF TERRAIN AND COMMUNITY** :

Southern half of the Chaka Block has been taken as the project area. It is situated along the bank of river Ganga. The area has direct links with the Naini industrial area. Although most of the area is linked with metallic roads,certain pockets are inaccessible in rainy season.Its brief Statistical description is as follows :

Religion: Hindus-88.7%, Muslim-8.3%, Others-3.0%

Occupational structure: Agriculture-50.7%, Business-29.8%, Labour-10.3%, Service-8.9%, Others-0.3% .

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Average per capita income - Rs. 35.51
Literacy Rate: Male-54.7%, Female-18.2%, Total-38.9%
(Source: Base Line Survey Report-1987)

ACTIVITIES DONE THROUGH PVOH GRANT :

All activities are covered under following heads :

CARE OF MOTHER

a) Immunization programme for tetanus, b) Anti-anaemia treatment, c) Antenatal care, d) Intranatal care, e) Postnatal care, f) identification of High Risk Cases and their referral, g) Post delivery family planning acceptance.

CARE OF INFANT AND CHILDREN

a) Follow up by Paediatrician, b) Nutritional advice,
c) Immunization programme: 0-1 year- DPT, BCG, Polio, Measles
1-5 years- DT
d) ORS- awareness thereof, e) Prophylaxis against nutritional anaemia, f) Prophylaxis against blindness.

FAMILY PLANNING SERVICES

Tubectomy, Vasectomy, IUD, Nirodh, Oral Pills.

HEALTH EDUCATION

Individual contacts, Group meetings, Mass meetings, Exhibitions, Film Shows, Katha, Kirtan, Bhajans, Drum beating.

ENVIRONMENTAL SANITATION

Talks on environmental sanitation practices,
Explaining the construction of low cost toilets for community,
Explaining the need of proper garbage disposal/compost pits,
Construction of Compost pits/garbage disposal,
Construction of Community toilets,
Construction of Smokeless Chulhas.

TRAINING PROGRAMME

Training for Gram Pradhans,
Training for indigenous practitioners,
Training for Dais,
Training for Volunteer mothers,
Training for Multipurpose Workers,
Training of elderly ladies of families actually performing deliveries at home.

IIb DATA INDICATING CHANGES IN HEALTH INDICATORS :

Following are the indicators which reflect changes in the health status of the population residing in the project area :

KAMALA NEHRU HOSP., ALLAHABAD
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Indicator	Status before commencement of the project 1987*	Present status 1990**
Women receiving antenatal care by trained personnel.	20.0%	95.8%
Women receiving TT(ANC) vaccination	25.3%	83.7%
Women receiving Iron and Folic Acid Tablets	19.4%	76.0%
Deliveries conducted by T.B.A.S.	21.4%	43.8%
Immunization		
BCG	18.1%	99.6%
DPT	18.7%	93.0%
Polio	20.7%	89.2%
Measles	9.5%	70.0%

*SOURCE- Base Line Survey 1987 ** Upto March 1990

K.N.M. Hospital had been established with the twin objectives of giving a living memorial to "the women of great spiritual beauty" Smt. Kamala Nehru and cater to the health needs of women and children.

A humble beginning was made on Feb.28,1941 with just 40 beds of Obstet. and Gynaecology. Since then, it has been expanded to a multifacet 306 bedded(213 free + 43 full-paying 40 Cancer+10 Post-operative)Hospital. In the diagnostic field it has got a well developed X-ray and Pathology Wing.Recently RT 3000 ultrasound equipment and Hitachi IV generation whole body scan machine have been added to it.

In the field of Cancer treatment there are Janus-60 and Theratron 780C with Cobalt 60 source and for the treatment of internal cancers and selectron machine with cesium source.

On the O&G side,the yearly OPD attendance is in the range of 35,000 to 40,000. The number of deliveries and abortions have been nearly 10,000. A lot of stress has been laid on family welfare work and its record is among the best in UP.

It has taken up a programme of providing health care at grass root level to a population of 51,888 of Southern half of Chaka Block and three urban slum areas of Allahabad city covering a population of about 1,11,000.

In its golden jubilee year it has been proposed to take up massive modernisation and expansion of the hospital in next half century to strengthen the bond between science and humanity. Construction of a new seven storied building having 350 beds with most advanced equipments and facilities for O&G and paediatrics has been started. The expansion of Cancer Wing with addition of Linear Accelerator is in the offing. On O&G side infertile couples are proposed to be 'gifted' by 'in vitro' fertilisation. The

facilities of Modern Blood Bank are expected to be provided in near future.

IVa IMPORTANT LESSONS LEARNT BY OUR ORGANISATION FROM THIS ACTIVITY :

Following are the important messages of this Project :

1. Village heads should be involved in all health activities with a well well framed training programme.This involvement makes the villagers to take the programme seriously. We have a pleasant experience in this direction.
2. Mothers should be focal point of entire programme,backed up by the specialised training.Results so far have been very encouraging.
3. Our training programme for elderly ladies of village who actually conduct deliveries has been an innovative idea. In this way, we have minimized the risk of maternal deaths.
4. Professionalism is a must in such projects.Every field worker should be given realistic targets and achievements should be monitored regularly with a strategy to share the experience of field workers.

IVb PLANS OF THE ORGANISATION TO SUSTAIN ACTIVITIES NOW BEING CARRIED OUT UNDER PVOH GRANT AFTER SEPT. 30, 1990

After 30 Sept. 1990 when PVOH grant will cease, the rural health programme will be modified as "Need Oriented" w.e.f. 1.10.90 to give total coverage to entire project population as hitherto.

Accordingly there will be recasting of staff to meet the new realities. The mobile team will cover all 10 Sub-centres once in 10 days. At each subcentre, one male worker will be stationed to arrange Clinics by Mobile team and keep the entire population informed of the day of visit.The worker will also arrange camps as per requirement of the rural population under their subcentre area.

In order to run the Rural Hospital, some income will be generated by the following proposed methods :

1. Charges of OPD tickets,admission,operation and medicines, 2. Income from surrounding factories who want to utilise the services of the hospital for their employees, 3. Income from horticulture,arrangement of melas by agro-based industries and fertilizer industries,donations and Govt. grants.

Following free services will be provided with the assistance of State Govt. as National Health Programmes :

Immunization, Antenatal, intranatal and postnatal care, prevention of blindness programme, malaria eradication programme, prevention of communicable disease and others.

TO SERVE THE POOR IS TO SERVE GOD

K.E.M. HOSPITAL, PUNE
P.V.O.H. PROJECT OF GOI/MOHFW

BRIEF HISTORY OF THE ORGANIZATION

PVOH I Project was undertaken jointly by the King Edward Memorial Hospital (KEM) and Indian Institute of Education (IIE), Pune.

The K.E.M. Hospital is a NGO established in 1912. It started as a small hospital for women and children with 25 beds and over the years it has grown and today it is a general hospital with 500 beds. The IIE is a public trust specialised in non-formal and adult education. It prepares teaching and learning aids and is also engaged in experimental field projects in adult education.

ACTIVITIES THROUGH PVOH-I GRANT: The project covers approximately a population of 1,46,000 spread over 70 villages in Haveli and Sirur Tehsils of Pune District in Maharashtra State.

Overall communication facilities in the project area are satisfactory except few villages during heavy monsoon. The villages have a number of hamlets and 40 to 60% of people live therein and are mostly engaged in farming. Villages in Haveli Tehsil receive heavy rains as they are located at the foot of hilly area; while those in Sirur Tehsil receive scanty rains. Four main rivers pass through the project area, however, all of them will be dry in summer. Literacy rate in Pune rural district in which the project area is located was 42.7 (1981 census). Major occupation is farming, however, the project area being close to Pune, which is a rapidly developing industrial city, migration to the city is on the increase.

ACTIVITIES:

1. DEVELOPMENT OF WOMEN'S FORUM: Informal education of women through MAHILA MANDALS, education SHIBIRS of one week duration was attempted with the assistance of trained Educational Coordinators (Male) and Animators (Female). BALWADIS were run by trained Animators and Child to Adult approach also adopted.

2.MOBILE HEALTH UNITS: Two mobile health units were established to provide basic health care services to remote and inaccessible villages and also to carry out health education activities. These units were manned by para health professionals like ANMs and Multipurpose Assistants.

(Assisted by the U.S.A.I.D.)

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K.E.M. HOSPITAL, PUNE
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3. OPHTHALMIC UNIT: A Mobile Ophthalmic unit manned by an Ophthalmic Surgeon and one Ophthalmic Assistant visited all the villages of the project in rotation to provide ophthalmic care and to give education to the rural people on eye care. The unit also carried out cataract operations at five primary health centres in rotation. Besides a static ophthalmic clinic was established at Vadu Rural Hospital.

4. HEALTH POSTS: The concept of a Health Post which is to establish the most peripheral unit of health care was developed. Accomodation was provided by local Gram Panchayat. Simple First Aid Box and home nursing equipments like hot water bag, urine pot, thermometer, spittoon including essential furniture were provided for village meetings. These centres were run by CHVs, Animators or the Gram Sevak who were given initially training on the use of the equipments.

5. CONSTRUCTION PROGRAMME:

i) Two quarters for the Resident Medical Officers were constructed at Vadu
ii) Water supply scheme for Vadu Rural Hospital was completed.
iii) Two sub-centres-cum-community welfare centres were constructed.

PROCESS INDICATORS: The following table gives some of the important indicators which reflect the progress made during the project period:

INDICATOR	ACHIEVEMENTS		
	1987-88	1989-90	% increase in 1989-90 over 1987-88
IMMUNIZATION:			
D.P.T. (3 doses)	3670	3987	8.6
Polio (3 doses)	2722	3627	33.2
BCG	3335	4429	32.8
Measles (Recently started)	1094	1166	6.6
FAMILY PLANNING:			
Sterilization	959	1308	36.4
IUD Insertions	583	950	63.0
Oral Pills Distributed(Cycles)	4921	9620	95.5

M.C.H. Registration of ANCs has improved substantially and is almost 100% at present.

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K.E.M. HOSPITAL, PUNE
P.V.O.H. PROJECT OF GOI/MOHFW

SOME HIGHLIGHTS OF THE ACTIVITIES OF K.E.M. HOSPITAL, PUNE:

The K.E.M. Hospital is today a 500 bedded hospital with all the specialities and super specialities and sophisticated equipments like CAT-SCAN, Ultra Sonography, Duplex Doppler, Laser, etc. The hospital is involved in both undergraduate and post-graduate medical education in collaboration with B. J. Medical College, Pune of Government of Maharashtra. It also runs a Nursing School for training of Nurses and Female Multipurpose Workers. The hospital has established a RESEARCH CENTRE which undertakes Clinical and Community-Based studies in collaboration with the Ministry of Health and Family Welfare, I.C.M.R., W.H.O. and UNICEF. As many as 22 research projects are going on at present. A Scientific Advisory Committee reviews periodically the progress made in the research projects.

VADU RURAL HEALTH PROJECT: A rural health project covering a population of approximately 40,000 spread over 22 villages is run by the hospital since 1972.

In 1977 Community Health Guide scheme was introduced which later on became a part of the National Programme. A rural hospital with 35 beds has been established at Vadu and since last six years it has been providing routine health care services as well as services of specialists on weekly clinic basis.

An ambulance service is provided for shifting serious patients promptly from Vadu to K.E.M. Hospital.

In the course of last ten years the project has been able to demonstrate significant improvement in the health status of the community. The crude death rate has declined from 10.4 per 1000 population in 1978 to 7.3 in 1988. Infant mortality rate has significantly gone down from 118 to 67 in the same period.

FUTURE PLANS:

i) A rural hospital on the pattern of Vadu Rural Hospital is planned in Maval Tehsil of Pune District. The area is hilly and has a tribal population of 7%.

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K.E.M. HOSPITAL, PUNE
P.V.O.H. PROJECT OF GOI/MOHFW

ii) Reduce perinatal mortality in Vadu Rural Health Project Area.

iii) A programme for prevention treatment and rehabilitation of deafness will be developed.

IMPORTANT LESSONS LEARNT:

i) Good health care services and education if truly integrated, will improve substantially acceptability and utilization of services.

ii) Women's Educational Shibirs organized under PVOH-I programme were found to be very effective in educating rural women.

iii) Concept of establishing a Health Post in every village needs to be tried further.

iv) Social changes in beliefs, attitudes and practices in rural communities cannot be brought about in a short period of 3 years.

PLANS TO SUSTAIN ACTIVITIES AFTER SEPTEMBER 1990:

K.E.M. Hospital, Pune plans to continue the activities, initiated during the PVOH-I phase in the project area with emphasis on the educational activities for a further period of five years subject to availability of resources. While doing so, the lessons learnt so far will be taken into account.

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KHAIRABAD EYE HOSPITAL, KANPUR
P.V.O.H. PROJECT OF GOI/MOHFW

I. **BRIEF HISTORY OF THE ORGANISATION**

The hospital was founded in the year 1975 in a posh locality of Swaroopnagar,Kanpur, on a plot of land so generously alloted to it by the then Chief Minister of Utter Pradesh, Chaudhary Charan Singh. Its foundation stone was also laid by him.

A few philanthraphists such as Mrs. Bajoria,the then Managing Director of B.I.C. Kanpur and some social workers extended their help in terms of money and organisation of its activities. The hospital owes a great deal to them for their initial help which was most needed at the time of infancy of the hospital. Since then the hospital has been serving most devotedly to rich and the poor alike,with particular emphasis on the rural population where the curse of blindness is more rampant than in the Urban areas.

With a view to ensure accessebility of the rural poor to our activities, we have established three rural Branches in Pucca building at Rania, Bilhaur and Ghatampur, one at each of three Tehsils out of five of Kanpur Dehat District. This in fact has made possible for us to reach our services almost at the door steps of the rural poor. The services in Base Hospital at Kanpur are also available to the Rural poor as and when required. The quality of service rendered by the hospital has raised its popularity immensely in a short period of time.

IIa. **DESCRIPTION OF ACTIVITIES DONE THROUGH THE PVOH GRANT.THIS SHOULD INCLUDE A BRIEF DESCRIPTION OF THE COMMUNITY AND TERRAIN AS APPROPRIATE**

As already indicated in the foregoing para the popularity of the hospital grew so fast that the attention of the Govt. of India/U.S.AID was also drawn to it allotting to us 80 lacs project for Eradication and Prevention of Blindness under the PVOH Scheme. We have undertaken the following activities under the said project:-

(1) Construction of Mini Eye Hospitals in Rural Areas.
(2) Training of Parameds/Medical Officers.
(3) School Survey. (4) Teachers Training.
(5) Eye Relief Camps.(6) N.P.S. (Netra Parikshan Shivirs or Eye Testing Camps).
(7) Village Surveys. (8) Mass Education.(9) Base Line Survey.

(Assisted by the U.S.A.I.D.)

KHAIRABAD EYE HOSPITAL, KANPUR
P.V.O.H. PROJECT OF GOI/MOHFW

Ib. **WHATEVER DATA THAT YOU HAVE, INDICATING CHANGES IN HEALTH INDICATORS SINCE THE START OF THE PROJECT.**

At the start of the project we had tried to assess the magnitude of the problem of prevalence of blindness in our area of activity. In fact in rural area 65% of the population was found to be having vision 6/60 or less. The total of 2562 pattern cases were seen and 102 were operated leaving a backlog of 2460 before our project. During this peoject period 6790 eye operations were performed by us. Thus clearing the backlog and also taking care of incoming cases. This has helped reduce the blindness figure to a considerable extent, which shows that such a model if replicated in other areas of work,the blindness can be controlled in this country.

I. **BRIEF ACCOUNT OF ACTIVITIES BEING CARRIED OUT BY THE ORGANISATION**

The basic aim of the activities of this project were to set up infra-structure of services in order to provide eye relief and eye care in the primary to tertiary cases.It is proposed to strengthen the concept and extend it to other areas within the Kanpur District and Dehat. The basic strategies followed were :-

1) Eye health education.
2) Delivery of eye health services through permanent Infra strucutre with adequate referal system.
3) For this purpose it will be necessary to update the technical equipment and also to increase skills of the manpower working and to provide the manpower with adequate facilities for upgradation of this course by training in sister institutions.

Va. **IMPORTANT LESSONS LEARNT FROM THIS ACTIVITY BY OUR ORGANISATION**

The important lesson learnt from this activity by our organisation is mobile unit providing eye health coverage yet they are inadequate and cannot serve the population on a permanent basis.

It is, therefore, necessary that the strategy should be on development of Infra-structure of eye care service, continuous development of manpower and initiate research in common problem affecting the areas.

KHAIRABAD EYE HOSPITAL, KANPUR
P.V.O.H. PROJECT OF GOI/MOHFW

IVb. **PLANS OF THE ORGANISATION TO SUSTAIN ACTIVITIES NOW BEING CARRIED OUT UNDER PVOH GRANT AFTER SEPT'30,1990**

The activities undertaken during the PVOH grant will be sustained by the efforts of the base institution of the organisation through which this project was carried out. However, if the activity can be supported even to a limited extent for 2 to 3 years more it will enable the organisation to not only sustain the activity but increase its efforts.

BRIEF RESUME OF WORK DONE UNDER THE PROJECT.

This project was the first of its kind in the country. We are probably the first eye Institution in the country who created a permanent Infrastructure in the rural areas in Kanpur Dehat, establishing three mini Eye Hospital called Eye Care Units.

Uptil March'1990 we have examined 213353 persons and operated 6799 (Major operations).

1. **Construction of Mini Eye Hospitals in Rural Areas.**
Under this we have constructed three rural Eye Hospitals at Bilhaur,Rania and Ghatampur through which thousands of poor people have been examined,treated and operated. Each unit has its own OPD, own Wards,Operation Theatre etc.
2. **Training of Parameds/Medical Officers.**
8 Medical Officers and 31 Ophthalmic Assistants have been trained by us.
3. **School Surveys.** During the project period under the School Survey programme conducted by our special and trained team 24,570 children were examined.
4. **Teachers Training.**
We found that it was impossible to get all the children examined by our team and hence the idea of Teachers Training was evolved. We organised 8 two days Teachers training Crash Course and trained 386 Teachers. This was a two days crash course in which they were told about basic Anatomy, Physiology, Communicable eye diseases and how to prevent it.
5. **Camps.**
We organised 58 Eye Relief Camps during the period of project.34,495 patients were examined in OPD, 34,495 patients were given immediate relief for different eye diseases.4236 Major operations and 254 Minor operation were performed in these camps.

(Assisted by the U.S.A.I.D.)

KHAIRABAD EYE HOSPITAL, KANPUR
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6. **N.P.S. (Netra Parikshan Shivirs or Eye Testing Camps).**
We sent our Mobile Van to various village and conducted Netra Parikshan Shivirs.The team consisted of Hospital staff including a Doctor and Paramedical staff. In N.P.S.,O.P.D was attended by 11,142 patients out of which 3247 cases of refraction were done and immediate relief was rendered to other patients.

7. **Village Surveys.**
495 Village visits were conducted by our medical and para-medical staff during the project in which 14,007 patients were examined. Refraction was conducted for 3414 cases.

8. **Mass Education**
Mass education on the prevention of Blindness and Eye health care was given to masses by distributing thousands of pamphlets/posters/handbills and 315 Slide shows were organised. Cinema Films were shown to the masses relating to the prevention of blindness.

9. **Baseline Survey.**
Again this is probably the first of its kind in the country. The only survey available as regards to the prevalence of blindness in this country was conducted by the Indian Council of Medical Sciences in the year 1971. After that we are probably the only institute which carried the Baseline survey.

(Dr.Y.K.Mahendra)

(Assisted by the U.S.A.I.D.)

KRISHI GRAM VIKAS KENDRA, RANCHI
P.V.O.H. PROJECT OF GOI/MOHFW

I. HISTORY:

"KRISHI GRAM VIKAS KENDRA" of USHA MARTIN INDUSTRIES LTD. RANCHI RUKKA Inception was done in 1972 as a trust and on first April 1977 as a society. Originally near factory premises TATISILWAI, later shifted to Rukka in 1982.

Medical Wing of KGVK was started on first April 1985 with adoption of 49 villages covering 50,000 population in the Tribal Belt of Chhotanagpur Division of Ranchi District of Bihar, with the aim of Maternal and Child Care, reducing Morbidity and Mortality.

To achieve the short term purpose and long term goal of this project three channels of approach envisaged:

a) Educate the Rural Population and personnel community health and hygiene and to provide physical aid for the sustenance of community health.
b) Train sufficient number of young men and women in the various skills involved in rendering medical first aid to the needy and medical counselling.
c) To make elementary medical treatment within the reach of every poor villagers and motivate the eligible couple for family planning and get the operable couple operated.

DESCRIPTION OF COMMUNITY CULTURE & TERRAIN:

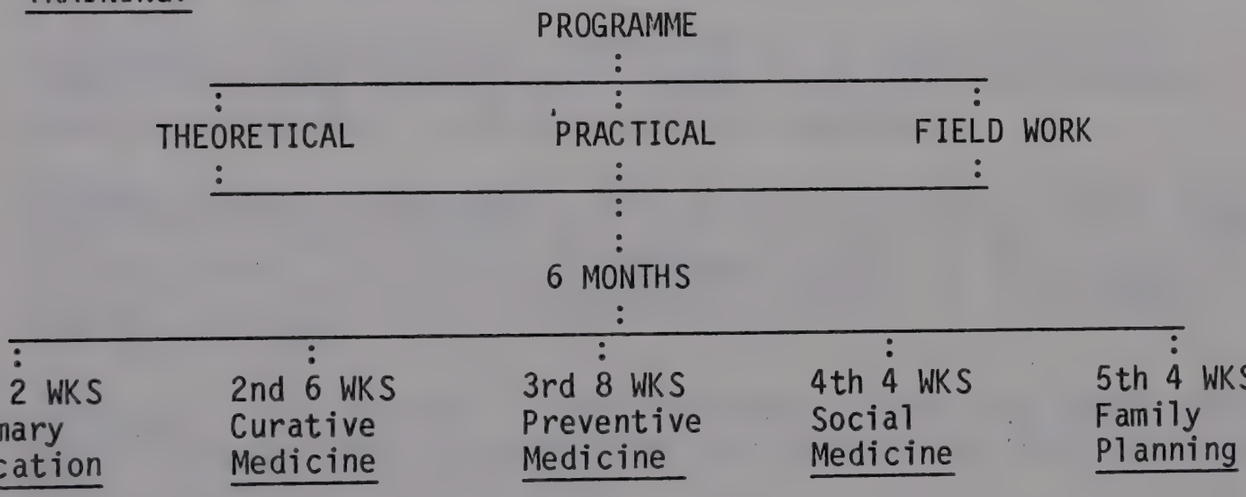
hhotanagpur Division of Ranchi District is a plateau over two tips of flat op ranges of Chhottanagpur. This small plateau is 2100 feet high from ea-level. Generally considered Hill-Station of Bihar State. Weather enerally cold and healthy. Rain fall is generally average (50-60" nnually). As a result of rocky soil and small hilly river, 8-9 months in a ear is usually dry and faces water shortage, water table is also not easily ccessible. Basically one crop of Rice, Maize, Marua, Gundli etc. is arvested in a year. Rest 9 months they go out of small villages to work to arn their living. Economically they are very backward. They basically epend on forest for their livelihood. Interestingly, it is the female who arn mostly for the family, but socially men are considered head of the family nd society. Role of women though important; position is not considered mportant in tribals. They have a few castes like Oraon, Munda, Bedia, etc. asically people are illiterate. Only few have done village level education. ney believe more in earning their livelihood than education. Tribals live imple life. They mostly live in huts of wood and leaf, few have mud and clay uts. Dowry during marriage is not prevalent though fun, frolic,

gaiety with dance and local Haria liquor is part of every celebrations and festivity. Their dress is very simple - dhoti and looga which is generally colourful. But they CERTAINLY do not believe in practicing family planning.

II. (a) ACTIVITIES:

Theme of the project is preventive than curative. Training was imparted to 26 health workers and 3 health educators at nerve center HCMC RUKKA.

1. TRAINING:



2. Functioning is divided in two categories:
SUB CENTER LEVEL; and
HCMC LEVEL

SUB CENTER LEVEL

a) Immunization: From scratch in 49 villages under 13 sub centers almost achieved the goal of 90%. Work though was difficult but not impossible with proper record keeping, follow up and persuasion.

b) Ante natal & Postnatal: This job was extremely difficult. Villagers were ignorant of ante natal care and overcoming village Dais was also a major problem. But by educating the villagers the iron curtain was broken and slowly women started coming for check up, inoculation and delivery. Now 60% of women folk are covered.

c) Hygiene: During village visits villagers were taught about importance of clean living, preparing nutritive food out of available resources and disposal of excreta, etc.

KRISHI GRAM VIKAS KENDRA, RANCHI
P.V.O.H. PROJECT OF GOI/MOHFW

III. KGVK RUKKA/RANCHI of UMI LTD.

Work for improvement of rural economy through integrated Rural Development programme directed towards making optimum use of available resources, distribution of inputs, application of science and technology, facilities of storage and marketing.

1. Animal Husbandry: Through Dairy Demonstration providing training to the Farmers in the art of better management of dairy cattle. Training the tribal youth for artificial insemination with frozen semen.

2. Agriculture & Horticulture: RUKKA FARM has an agriculture cum horticulture wing, suiting Ranchi weather and soil, for teaching farmer to get better yield of crop/fruits/vegetables.

3. Cottage Industry Development: KGVK tries to provide necessary help after eliminating obstacles that cause low return to get better return of the product. Also helps to supplement family income by various cottage industries such as production of utensils by scrap metals, silk industry etc.

4. Education: KGVK stresses on education most, by building small schools for village children and monitoring from time to time their curriculum and assistance of teaching aids.

   Adult education is also done once a week in a village choupal with the help of audio-visual media, demonstration, light cultural activities and health education.

FUTURE PLANS: KGVK is liaisoning with government developed agencies and combining with government resources after studying the needs of farmers. Formulate a scheme and monitor it so that goods are delivered through single window delivery system instead of making them run from pillar to post. Also to look out for new rural based projects to enhance the income of poor tribals.

IV. (a) IMPORTANT LESSON:

Training/Selection of team: We felt difficulty in giving training to boys and girls from villages because of their low receptive power and no proper basic education. We have to develop our special skills while teaching them. We try to teach them in simplest manner with the help of audio-video devices, etc.

d) Well Chlorination: All wells for drinking water purpose were protected and prevented by the team in all 49 villages.

e) Yuva Mandal & Mahila Mandal: Yuva Mandal and Mahila Mandal meeting are held time to time to impart health education to villagers, teach them sewing and tailoring; prevent addiction by showing picture, slides and audio-visual demonstration. Health workers also participate in cultural activities of villagers to gain their confidence.

f) Family Planning: Main thrush was given to family planning activities, motivation with educational films, demonstration, lectures, etc.

HCMC LEVEL:

All referred case from sub centers are treated. All kinds of treatment and all sort of routine investigations are carried out at HCMC. Operations like Hernia, Hydrocele, Appendix, Caesarean section, D&C, D&E, Tubectomy and Vasectomy are done. Facility for nursing premature baby is also available.

II. (b) The comparative data of various indicator of health as per base-line survey conducted at the inception of the project in 1985 and that in 1990 is given below:

Indicator	At 1985	At 1990	Inference
Immunization			
- Polio	Nil	84.42%	
- D.P.T.	Nil	84.69%	
- Measles	Nil	50.00%	
Vit. A. Prophylaxis	Nil	65.06%	
Pre-natal care	Nil	64.00%	
Post natal care	Nil	80.00%	of A.N.C.
Crude Birth Rate	35.07	22.80	
Crude Death Rate	15.07	3.06	
Infant Mortality Rate	126.00	90.13	
Family Planning Adoption	14.07	68.00%	

KRISHI GRAM VIKAS KENDRA, RANCHI
P.V.O.H. PROJECT OF GOI/MOHFW

Village Front: Piercing the Iron curtain of shyness and ignorance of illiterate tribals was a big task to achieve and not the hurt their cultural as well as social faith. It was not easy going even for local field workers to organize demonstrations/lectures for the villagers.

Finance: Financial hurdle was also a gigantic task. Resources being less and earning being poor, an expectant mother/growing child could not be given proper nutrition, care, rest and treatment.

Block Staff: By and large, administration of state government has given full fledged support and help from time to time but at Block Front, field workers of government shown discontentment often in petty matters like incentive money of family planning operation; malpractice of charging money during deliveries etc.

Future Plans:

1. For better sustenance, government coordination and cooperation has to be maintained at all levels in terms of assistance like incentive money, free drugs, vaccines, financial help, etc.

2. Coordinate with project body to corporate some more project in the running project so the interest is kept alive and functioning partly becomes smooth.

3. Charging money for drugs and nominal fees for operative treatment, deliveries, etc.

4. Approach few more agency for working donations only for better functioning.

5. Tap self resources also to increase financial contribution.

(Assisted by the U.S.A.I.D.)

K.S.D.N.G. COL. OF OPTHAL., NAVSARI
P.V.O.H. PROJECT OF GOI/MOHFW

I. BRIEF HISTORY OF THE ORGANISATION

Rotary Club of Navsari established Rotary Eye Institute and started Lilavatiben Mohanlal Shah Eye Hospital in 1977. Shri Bhanabhai Gohil and Shri Maganlal Dahyabhai Gohil prominent businessmen in Fiji and Hongkong and also trustees of the Rotary Eye Institute promoted the idea of the College of Ophthalmology with specialised Medical and Surgical services for dialysis, Coronanry care, Neuro and Paediatric Ophthalmology. Thus K.D.N.Gohil College of Ophthalmology and Research, Navsari was promoted jointly by Bhanabhai and Maganlal International Foundation Trust and the Rotary Eye Institute. The institution has been registered as a Public Trust in 1980.

II.a. DESCRIPTION OF ACTIVITIES DONE THROUGH THE P.V.O.H. GRANT.

TITLE OF THE PROJECT : Community Ophthalmology.

AREA AND POPULATION : 5 out of 8 Talukas of Valsad District.

Number of Villages : 598, Total Population : 10,61,451

Majority of the population is of Adiwasis and other Backward classes.

ACTIVITIES :

1. TRAINING

Training to Medical Officers and other Para-Medical Staff of all the 20 Primary Health Centres (P.H.Cs.) of entire Valsad District was arranged at K.D.N.College, Navsari.

	Medical Officers	B.E.Es.	Health Supervisors	M.P.Health Workers	Group Teachers
Numbers Trained	87	29	121	274	159

2. BASE LINE SURVEY

It was carried out through Ophthalmic Assistants of 15 P.H.Cs. comprised in the project area and two Mobile Units. Survey Report was submitted to Govtt. of India and N.I.H.F.W. on 27th April 1988.

3. HEALTH EDUCATION

Health Education was imparted to the Community by Health Educator, Ophthalmic Assistants and two Mobile Units, through:-

a) Group Meetings : 1680 (b) Individual Contacts : 14749
c) Exhibition : 160 (d) Camps : 191 (e) Posters : 2000
f) Pamphlets : 10,000

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K.S.D.N.G. COL. OF OPTHAL., NAVSARI
P.V.O.H. PROJECT OF GOI/MOHFW

4. DIAGNOSIS & TREATMENT

It is done at the following (a)(b) and (c) levels by:-
(a) Ophthalmic Assistants and Mobile Units at P.H.Cs and at Villages covered. The cases requiring indoor treatment and operations are referred by them to the concerned Rural Eye Care Hospital (REC) situated at Taluka level.

There are 15 PHC's in the Project area. One Ophthalmic Assistant (O.A.) with necessary equipments is posted at each P.H.C. 30 to 50 villages are attached to each P.H.C. Ophthalmic Assistant attends OPD for a day or two in a week at PHC and during rest of the days visits villages attached to the PHC for Village Survey School Children check up and Health Education. He also accompanies the Mobile Unit whenever it happens to visit his PHC and villages attached to it.

There are two Mobile Units. One is attached with two R.E.C.Hospitals and other with three R.E.C. Hospitals. Each Unit has necessary equipments and is operated by Ophth.Surgeons of R.E.C. Hospitals attached to it alongwith the concerned Ophth. Asstt.

(b) RURAL EYE CARE CENTRE HOSPITALS (REC) AT TALUKA LEVEL

Each REC serves the area of 2 to 4 P.H.Cs. and a total population of about two lacs and above. Each has all equipments and facilities to tackle all Ophthalmological problems, including Cataract and Glaucoma operations and Minor Surgeries. They are the referral centres for OAs and Mobile Units. Each has an Ophth. Surgeon, One O.A. Two Nurses, One Ayah, One Ward boy, a Peon and One Clerk-cum Accountant, REC Hospitals at Taluka level are at (1) VAPI (2) DHARAMPUR (3) CHIKHLI (4) UMBERGAON and (5) Nani Bhamti (BANSDA). New Hospital Buildings have been constructed at (1) to (4) Places, out of the project fund. Each new building has floor area of 3000 sq.feet with OPD, O.T. Ten Beds on the ground floor and staff quarters on the first floor. REC at No.(5) is located in the premises of the other Trust.

(c) Base Hospital at Navsari (Rotary Eye Institute, Smt. Lilavatiben Mohanlal Shah Eye Hospital)
It has a large OPD with 285 beds. It is a principal referral centre for OAs, Mobile Units and R.E.Cs. for all types of complicated cases and Operations. It has an Eye Bank and Cornea Grafting is also done here.

DETAILS OF PATIENTS TREATED AND OPERATIONS CARRIED OUT

K.S.D.N.G. COL. OF OPTHAL., NAVSARI
P.V.O.H. PROJECT OF GOI/MOHFW

	Treated			Operated		
	O.P.D. Cases	Refer-action	Others	Cataract	Glaucoma	Others
(a) OAs and Mobile Units	36120	12684	6726	-	-	-
(b) R.E.Cs.	40275	10068	19622	862	60	1522
(c) Base Hospital	198116	142023	31435	10023	1217	13318

5. SUPERVISION & MONITORING

It is done by Central Project Office at Navsari. It consists of a Project Director, Accountant-cum-Administrator, Health Educator Steno, Statistician (Post discontinued from 1-9-88) Store Keeper, a Driver and a Peon. It has a jeep for outdoor duty.

II.b. DATA INDICATING CHANGES IN HEALTH INDICATORS

So far Ophthalmology is concerned the main causes leading to Blindness are "Vitamin A deficiency" in childhood and "Cataract" in the old age. The figures of annual targets and achievements for Valsad district for these two items are given below:

T = Target A = Achievements

	1985-86		1986-87		1987-88		1988-89		1989-90	
	T	A	T	A	T	A	T	A	T	A
i) Vit. A Deficiency	92808	95544	104871	101499	102960	110541	104000	110807	10400	114882
ii) Cataract	4050	4080	3617	4198	5246	2983	3617	3619	3619	4444

The achievement is nearly or above 100%. These figures do not indicate changes in Health Indicators. Changes could be known only if annual or periodical surveys are carried out. The organisation has not taken up such surveys.

III. BRIEF ACCOUNT OF THE ACTIVITIES CARRIED OUT BY ORGANISATION

In addition to Community Ophthalmology, the organisation has started the Department of Cardiology since last one year with Intensive Cardiac Care Unit equiped with modern instruments, to serve four patients at a time. It is proposed to start Departments of "General Surgery" and "Paediatric" during the current month. (July 1990)

ACHIEVEMENTS TO BE HIGHLIGHTED

The organisation has provided five Eye Hospitals at Taluka level

K.S.D.N.G. COL. OF OPTHAL., NAVSARI
P.V.O.H. PROJECT OF GOI/MOHFW

under the project, thereby reducing the pressure of local patients at the Base Hospital and providing Eye Clinics at the door of the rural area. Base Hospital has done a commendable job of Cornea Grafting by maintaining an Eye Bank and has so far carried out cornea grafting in 1846 cases.

This organisation has like wise provided Intensive Cardiac Care Unit of 4 beds with continous Cardiac Monitoring System equiped with Defabrilators to treat acute (Myocardiac Infection) Heart attack affording life saving treatment, thereby providing an important facility at the door ofthe people of this District, relieving them from the botheration of rushing to the big city like Bombay.

OVERALL OBJECTIVES

The main objective of the organisation is to provide the latest facilities and treatment for all types of diseases.

FUTURE PLAN

The institution proposes to hold diagnostic camps for all diseases in Valsad District, and to carry out health check up of all students of School and Colleges of Navsari Town and surroundings and issue "Health Card" to each and every student in the first instance in the near future and take up new villages every year so as to cover the entire VALSAD District.

IV.A. IMPORTANT LESSONS LEARN FROM THIS ACTIVITY:

It is difficult to convince the Donors about the success of the Scheme in the beginning and as such until some substantial work is put up the donations are not pouring in, therefore, the scheme should be with 100% financial assistance from U.S.A.I.D. or Govtt. of India for the first two years and the total period of assistance be seven years. This would ensure a good and immediate start and sufficient period for an organisation to raise finance for continuance of the scheme on permanent and sound footing.

IV. PLANS OF THE ORGANISATION TO SUSTAIN ACTIVITIES BEING CARRIED OUT UNDER P.V.O.H. GRANT AFTER SEPTEMBER 30, 1990

Organisation has established Local Management Committees for each R.E.C. Hospital at Taluka under the control of this organisation. They will be continuing the services at present rendered and will cover all the villages by holding camps. Mobile Units shall continue to operate as usual. Ophth.Asstts. at P.H.C. level will be under the Distt. Panchayat as before and continue to discharge their duty independent of our organisation. In case of failure of any Management Committee, the organisation will directly take over the Management.

MAHARISHI DAYANAND, YAMUNA NAGAR
P.V.O.H. PROJECT OF GOI/MOHFW

Q.No. 1. BRIEF HISTORY OF THE ORGANISATION

The D.A.V. (Dayanand-Anglo Vedic) Trust and managing society was established over 100 years ago in 1886. This is the biggest Educational Trust and society in India running and controlling about Six hundred schools and colleges in the country and abroad. Apart from educational activities it has taken up to run Ayurvedic College, allopathic Hospitals and dispensaries; and other relief activities with special emphasis on widows, orphans, aged, handicapped and other backward sections of the society.
In Yamuna Nagar, the said Trust had set up and established 'The Maharishi Dayanand Maternity & General Hospital' which is also running a Dental College took up a project. " Primary Health Care Integrated with Health and Non-Formal Education" under USAID funded PVOH project of Govt. of India.

ACHIEVEMENTS DONE THROUGH THE 'PVOH' GRANT

Though, the project was sanctioned from Jan. Ist, 1987; the first installment of grant-in-aid was received only in March, 87. Consequently some of the project staff could be recruited from May, 1987, and only after that the project could reach the take off stage.
The achievements of our project are high lighted in two parts:

A. INFRASTRUCTURE AND HUMAN RESOURCES STATUS
B. SERVICES.

A. INFRASTRUCTURE AND HUMAN RESOURCES STATUS:

Urgent measures were taken to complete some of the basic activities over which the project was bound to build.

1. RECRUITMENT OF STAFF: At present we have almost full fledged staff except one post of Health Asstt. and one post of MPW(M).
2. CONSTRUCTION:
This activity has been delayed to some extent. The ministry has been requested to release the grant meant for construction after submitting all the required documents.
3. EQUIPMENTS AND FURNITURE:
The equipments and furniture for the project office and sub-centres are purchased as per the present needs.

(Assisted by the U.S.A.I.D.)

MAHARISHI DAYANAND, YAMUNA NAGAR
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4. VEHICLE:

One mobile Van, a Motor Cycle budgeted in the project has been purchased and six Bicycles as recommended by the monitering body have been purchased.

5. BASELINE SURVEY:

Baseline survey was completed and the report was submitted in May, 88.

6. TRAINING: We have been imparting training to various categories of personnel namely indegenous dais, village health promoters and non-formal education & dais training to women/orientation/refresher training is also imparted to the project staff during montnly meetings.

B) SERVICES: Infrastructure was established in stages, Services from the urban sub centre was started from August, 87. Subsequently, by October, 87 services from all sub-centres were started in rented buildings. Maternal and child case services improved considerably after May, 88 when ANMs for all the sub-centres could be recruited.

1. CURATIVE SERVICES:

i) AT THE SUB CENTRES: The basic services are given by MPW (M) and ANMs for two hours daily. Emergency cases are referred and kept for the doctor who visits each sub-centre on fixed days once a week. So far, 16,414 male, 19,820 female and 18,610 children have been treated/ referred.

ii) MOBILE CLINIC: The mobile van is fitted to meet all the emergencies. So far, 797 male, 704 female and 483 children have been treated.

iii) GENERAL MEDICAL CAMPS: These camps are regularly organised in the project area where in the specialists of the M.D.M. Hospital render their services to the community.

2. MATERNAL CARE SERVICES: i

i) Registration of pregnant women for antenatal care was 2121 of the estimated 2700 pregnancies. A minimum of four contacts were made with the registered pregnant mothers for giving necessary medical care. A total of

MAHARISHI DAYANAND, YAMUNA NAGAR
P.V.O.H. PROJECT OF GOI/MOHFW

1108 deliveries have been attended by the project staff. 1312 post natal mothers have been registered. Two to four contacts were made to give necessary medical care to post natal mothers.

ii) IMMUNISATION OF PREGNENT WOMEN: Out of the total ANC registration 62% pregnent women were immunised with tetnus toxoid.

iii) IRON & FOLIC ACID PROPHYLAXIS: The percentage of registered pregnent women receiving atleast one offtake of Iron & Folic Acid is 69.

c. CHILD CARE SERVICES:

i) CHILD REGISTRATION: The percentage of children registered between the age group of 0-1, 1-2 and 2-5 are 85% 94% and 62%. About two to three contacts were made with the registered children for giving necessary medical care.

ii) IMMUNISATION: Children between the age group of 0-2 years were immunised with DPT and OPV. DT is given between 5-6 years and TT at the age of 10 years. DT and TT immunisation were given in schools.

The percentage of children immunised with DPT for I, II, III & booster dose is 80%, 68%, 63% and 55%. And that percentage of children immunised with OPV for I, II, III & booster dose is 77%, 66%, 60% and 52%. The percentage of children immunised with BCG is 77% and that percentage for measles is 67%.

iii) IRON & FOLIC ACID PROPHYLAXIS: A total of 1725 children were identified as anemic and atleast one offtake of I/F tablets were issued to them who were followed up for II & III..... offtakes.

iv) VITAMIN 'A' PROPHYLAXIS: No. of children facilitated with Vit. 'A' between the age group of 1-2 yr. for I, II, III, IV & V dose is 1707, 882, 554, 79 and 19. And that number of 2-5 yr. children is 1922, 847, 777, 471, 211 and 62.

v. SCHOOL HEALTH PROGRAMME: The activities under taken in the School Health Programme are:
a) Immunisation with DT & TT vaccine.
b) Health Education to children.
c) Health check up of school children.

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Efforts are being made to contact each student atleast once a year.

vi) REHABILITATION OF MALNOURISHED CHILDREN:

The findings of serial neight, weight, mid-arm circumforence, and signs of malnourishment of children are being recorded and efforts are taken to follow up the records.

4. FAMILY PLANNING: We have been providing necessary motivation & counselling to people for adoption of various family planning methods. A total of 44 Tubectomies and 86 IUD insertions were achieved. 3420 condom pieces and 2217 OP cycles were distributed.

5. HEALTH EDUCATION: The health, family planning, MCH case and nutrition education is being imparted through individual contacts, group/mass meetings, orientation camps and film shows.

Q. No. iv.

a. The project is in service to humanity. Effective and cogent services to suffering patients from a variety of diseases have already been done. We, would continue to contribute our mite to this humanitarian task which we feel are real deposits in the Bank of Heaven where the encashment is available in the unborn ages to come and born in the subsequent birth when the selfless service is done to the humanity under all categories.

b. The D.A.V. organisation, being the biggest Trust in the country, proposes to continue the project after September 1990 as we have vast avenues at our disposal. We plan to continue the activities by enlarging the scope of the activities already in existance.

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MED.RELIEF SOC.,S.KANARA,MANIPAL
P.V.O.H. PROJECT OF GOI/MOHFW

BACKGROUND

The Medical Relief Society of South Kanara was established by late. Dr. T.M.A. Pai in the year 1960. The society established a 1500 beded complex with Kasturba Hospital, Manipal as apex hospital and a number of well organised outreach centres. This includes six MCH centres with a total capacity of 48 beds. The other outreach activities comprises of eye, dental and family planning camps and about 12 weekly specialist clinics in the periphery.

PROJECT AREA

The project area is located in Udupi Taluka of the Dakshina Kannada district of Karnataka. A rural population of 60,000 in coastal area and 25,000 in the interior area is covered under the project.

OBJECTIVE

The overall objective of the project is to provide comprehensive health care with special emphasis on maternal and child health care with active co-operation of the community and Government agencies working in the area.

The broad objectives are :

a) to provide improved domiciliary care especially in the field of MCH, nutrition and family planning.

b) to build up a good referral system.

c) to develop health education materials and carry out intensive health education activities.

d) Provide training to all categories of health personnel - specialists to paramedicals in delivery of MCH Care to rural population.

(Assisted by the U.S.A.I.D.)

COMMUNITY HEALTH CELL
326, V Main I Block
Koramangala
Bangalore-560034

e) to generate community participation and support in planning and implementation of health programmes.

ACTIVITIES AND ACHIEVEMENTS

During the three and half years of the project, we have been able to provide antenatal care to all the mothers living in the project area. Institutional deliveries increased from 67% to 93%. 80% of underfives could be fully immunized. BCC, OPV & DPT coverage was to the extent of 96%. Not a single case of Poliomyelitis was reported during the last two years. Eligible couple protection increased from 32% to 43%. 12,769 school children were examined in 42 Primary schools and 5,221 were referred for further treatment. Regular growth monitoring was undertaken in all the children below three years. Malnourished children were identified and intensive health education carried out for mothers of these children and remedial measures taken for improving nutritional status.

23,937 children attended the underfive clinics, 51,396 were treated in general clinics and 3,498 cases were referred to Kasturba Hospital.

238 school teachers were trained from 42 primary schools who in turn would be able to provide health education to school children. Refresher training was provided to Government paramedical personnel located in the project area.

Six video films and a number of other health education materials were developed by the project and health education imparted to mothers, school children and Public in general.

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HIGHLIGHTS AND LESSONS LEARNT

1. An innovative scheme of alternative strategy for the delivery of MCH care through village level volunteers was tried without much success. We failed to motivate volunteers to work without any remuneration. Probably some financial benefit could have changed their attitude.

2. We have developed a Medical Information System (M.I.S.) through the use of a computer for planning, monitoring and evaluation of the project activities. This is also helpful for planning and conducting resarch into community health problems.

3. It is possible to develop Health education materials, with the expertise of a medical college, on important health issues for the benefit of target audience like mothers, school children and general public.

4. There has been an alround improvement in the coverage of MCH services namely antenatal, intranatal, postnatal, underfive care and school health services in the project area.

   Thus, the project demonstrates that PVOH in partnership with the Government agencies can play a vital role of a catalyst in strenthening the existing health services.

5. The model of Rural Maternity and Child Welfare Homes backed up by the Medical College Hospital, an innovative approach for the delivery of MCH services, has two distinct advantages.

   (a) Quality MCH Care as available in a medical college, set up is brought to the door step of the people at a very low cost.

...4

b) The model serves the prime need of a medical college, in imparting training to undergraduates, interns and postgraduate students.

Thus the continuity of the services is ensured. Needless to say that such a project is economically viable and sustainable even after the withdrawal of funds of the donor agency.

FUTURE PLAN

All the activities will be carried out in future by the Medical Relief Society of South Kanara. Part of the expenditure for the health care will be borne by the community itself.

MORADABAD CHARITABLE TRUST
P.V.O.H. PROJECT OF GOI/MOHFW

I. Brief history of the organisation.

The organisation is a registered trust under the society registration act since February, 1985. The trust hag been rendering services to the community through the individual efforts of the trustees, by holding camps for detection of diabetes, eye relief, immunisation, school health check-up in rural and urban Moradabad. The organisation had also started two sub-health centres in rented building on the Govt. pattern to provide primary health care services in a permanant way before the start of this project.

II.a. Description of activities done through the PVOH grant. This should include a brief description of the community and terrain as appropriate.

Moradabad district has a population of above 32 lacs out of which 23 lacs is rural population. The organisation has proposed to undertake primary health care activities covering about 37,000 population. The nearest Govt. PHC covering these sub-health centres are about 40 km. to 16 km. respectively from village Mau where the community health centre is situated. The seven sub-health centres are in the radius of 0 to 20 km. from community health centre. Being nearest to the town lot of industrial workers, working in Moradabad district, are also residing in this area and so the diseases caused by the industrial hazards are also significant in this area.

The primary health care services are being provided through three tier structure:-
1. Seven sub-health centres. 2. One Mobile Unit
3. Community Health Centre.

1. The sub-health centres activities are being carried by A.N.M., Dai, and Male Health Worker the Medical Officer visits each centre every week. The services provided through the sub-health centres are curative treatment antinatal clinics and home visit

Contd....2....

by A.N.M. and Dais postnatal check-up. Aseptic domicialary deliveries, child welfare clinic, immunisation, correction of Nutritional Anaemia in mothers and children. The school health check-up done by Medical Officer. The sub-health centre also provide family welfare services, detection and control of Malaria, Tuberculosis, Leprosy etc. It also holds special camps film shows, baby shows.

2. The Mobile Van visits villages other than sub-health centre. It provides curative services at the door step of villagers. Pathological tests, x-ray are being done through mobile van. It also brings back patients to the community health centre who need special treatment.

3. The community health centre is fully operational with 30 beds. It conducts O.P.D. as well as Indoor services for the referral patient from sub-health centre.

II.b. Whatever data that you have, indicating changes in health indicators since the start of the project.

a) Survey :- As per list enclosed.

b) Achievement from 1.1.86 to 31.3.90 are below:-

Services	Target	Achievement I	II	III	B
1. Immunisation:					
T.T. Mothers (2 doses)	4540	3350	1404		
" Children 10 yrs "	4540	2008	1447		
" Girls 16 yrs "	4540	738	514		
D.P.T.	5944	5020	4697	4416	1016
Polio.	5944	5250	4567	4169	976
B.C.G.	5944	3553			
Measles	5944	3088			
D.T.	5944	3525	3292		
Typhiod	5944	1313	794		
Vit-A	26607	6584 Benificiaries.			

Contd....3.....

MORADABAD CHARITABLE TRUST
P.V.O.H. PROJECT OF GOI/MOHFW

	Target	Achievement
2. Maternity & Child Health programme:		
a) Regn. of pregnant mothers	4540	4388
b) Antenatal Re:visit	9080	10351
c) Deliveries	4540	3571
d) Postnatal Ist visit	4540	3673
e) Postnatal Re;visit	9080	9300
f) Infant registration	4540	5431
3. Reduction in nutritional Anaemia:		
a) No.of Iron (Big) Tablets dist.	402600	206879
No. of Benificiaries	4540	2988
b) No.of Iron(Small)Tablets dist.	402600	133199
4. Detection and control of Malaria-	9800	5889
5. Family Welfare Services:		
a) Contact for family planning	39480	11506
b) Vasectomy/Tubectomy	1260	12 Tub.
c) No.of Copper-T insertion	1260	178
d) No.of Nirodh pcs.distributed	75600	107582 pcs.
No.of Benificiaries	1260	890
e) No.of cycles of Oral Pill dist.	3780	3980
No.of Benificiaries	407	1260
6. Health Education Activities:-		
a) Individual discussion	12600	11911
b) Group discussion	2940	2506
c) Mass discussion	840	665.
d) Bhajan, Kirtan,		35
e) Lok Evam Pouranik Songs		2
f) Film shows	180	115
g) Baby Shows	60	29
h)School health education	240	278
i) School health check-up	115	98
j) Orientation lecture.	120	115
7. Environmental Sanitation:-		
a) Individual Dry Latrines		117
b) Soakpit		43
c) Smokless Chullhas		432
8. T.B.Camps: Total patient sdreened	-	1376
No. of sputum examined	-	443
Patient found positive	-	81

Contd....4....

MORADABAD CHARITABLE TRUST
P.V.O.H. PROJECT OF GOI/MOHFW

III. A brief a-ccount of activities being carried out by the organisation; achievement you want to highlight; its overall objectives and future plans.

The services given are antenatal, postnatal check-up, supervised deliveries, institutional delivery of sub-health centre of high risk antental case T.T. to pregnant mother, immunisation to children, treatment of common ailments of sub-health centres and specialised treatment at community health centre, correction of nutritional anaemia in mother and children, detection and control of malaria, tuberculosis, and leprosy, child welfare clinic and home visit, prevention of blindness by distribution of Vit-A to children. Medical check-ups of school children, inpatient medical carent community health centre. Handling of emergencies in the project area. Provision of family planning spacing method.

IVa. Important lessons learnt from this activity by your organisation.

Lesson:- Public awarenes and personal support are important factors in the success of any health project. This can be achieved by involving village heads, school teachers and other educated and social workers in villages and giving them orientation courses regarding health education going door to door and discussing their problems personally with individual, group and mass discussion creats great repport with public.

IVb. Plans of the organisation to sustain activities now being carried out under PVOH grant after September, 30, 1990.

After the end of PVOH grant in September 30, 1990 we would ask help from USAID for another extension. If not granted then from U.P.Govt. for the grant to our sub-health centres and community health centre. We are also planning to change normal levy from the patients, if no grant is being given. Lastly, we will take the help of people of Moradabad district to raising donations for this purpose.

(Dr.D.P.Manchanda)
M.D.
SECRETARY.

NEW CENTURY WELFARE, MADRAS
P.V.O.H. PROJECT OF GOI/MOHFW

I. BRIEF HISTORY OF THE ORGANISATION: A few doctors, philanthropic people, officials, business magnets etc., decided to come together and start a welfare society in northern part of Chinglepet District. The temptation was more since the local population voluntered to help us in these activities. With some effort, we formed a welfare society and named it "New Century Welfare Society". The article of memorandum was prepared concentrating on health and education activities and got registered in the year 1979. The incidental and ancillary to attainment of main objectives were included. Medical activities started with establishment of one out patient centre at Ambattur Township along with out-reach programme with the help of volunteers in Semi-urban, rural and slum areas.

Due to large attendance of out-patients and also increase in out door health activities, the organisation enlisted more staff and doctors. Visits to the surrounding places increased, due to increased activity towards immunisation, school health check-up etc., Donations for acquiring land for construction of Medical Centres at Kamarajapuram, Varadharajapuram & I.C.F.Colony were forthcoming and Building activities commenced before the society took up the PVOH - I Project. Educational activity started with establishment of school for lower classes, subsequently developing into a matriculation school. It is serving the poorer sections of the local population with minimal fees, low cost books, etc.

II. (a) ACTIVITIES DONE THROUGH PVOH GRANT: Ambattur Township comes under Chinglepet District of Tamil Nadu and is a suburb of Madras City, presently totalling a population of nearly 3 lakhs. Due to the large concentration of industrial establishments over the last decade, the population has doubled itself. Area profile consist of semi-urban, rural and slums. The terrain is mostly covered by roads but the slums and some of the rural villages have to be approached by foot only. It is a mixed population of casual labourers, artisans, agricultural and industrial labour belonging to Hindus, Schedule Castes, Muslims, Christians and Schedule Tribals, in that order of population. About 95% of population belong to either poor or middle class families.

The PVOH Project aimed, to expand and improve the basic and preventive health, family welfare activity, nutrition services, immunisation coverage, registration of pregnancies, supervised deliveries, medical check-up of school children, reduction of

first and second grade mal-nutrition, and supportive referral system covering a population of about 1 lakh, emphasis being given to preventive and promotive services. The curative services were confined to medical, surgical, obstetrics, dental and ophthalmic. Added to the above, healthy environmental living, sanitation, nutrition education, cooking demonstration, health education, construction of smokeless chullahs, mothers meetings and talks on personnel hygiene etc., were taken up.

A sample survey of about 25 thousand population were carried on at the initial stage, the basic objectives to provide comprehensive health care, (including basic health, preventive and promotive health care, M.C.H., Family Welfare, and nutrition services) to the poor and the weaker section of the society who are less well served, were achieved to a satisfactory percentage, through hard work and cooperation by the staff as well as public. We have been covering up all the above activities with a fair percentage of success. Our quarterly reports will give an indication towards that. All the above activities were carried on, with the establishment of 10 mini health centres, a referral centre with 20+6 beds.

We were able to fulfill all our committments towards PVOH-I Scheme including our share of the project expenditure (We have spent more than our share towards project activity) we have completed building four mini health centres, one referral centre with X-ray plant (New) fully equiped laboratory, operation theatre and delivery facilities. The Quarters for Doctors and Nurses are also completed. Ambulance, Jeep and Audio-Visual equipment were also procured.

We have been coordinating with local, state and central Governments agencies during epidemics like, cholera. We have also been coordinating with the central health programme like leprosy, filariasis, malaria eradication, etc.

II. (b) CHANGES IN HEALTH INDICATORS: PVOH-I Scheme is the first of its kind to the society, running for a period of 5 years. A survey has been conducted at the initial stage and until we go in for re-survey, the impact of health indicators may not be accurate and truly representative to determine changes in health indicators as rates and ratios. Efforts are being made to streamline data collection for refined analysis. In the absence of rates and ratios about health indicators we can only broadly

state the following:
IMMUNISATION: We have not come across a single case of diptheria and Tetanus during '89 and upto now. A substancial reduction in whooping cough is noticeable. Fresh cases of polio are rare. Due to constant impact of the health worker, pregnancy immunisation show a good percentage. NUTRITION: There is some improvement in nutrition deficiency cases but until economic conditions of the poor improve mal-nutrition cases will continue. There is improvement in the environmental sanitation but this also depends upon economic conditions, water supply, maintanance of sanitation, etc., Improvement have been noticeable in registration of pregnancy as well as supervised deliveries. Family Welfare operations and other methods have shown great increase among the population covered. School children check-up have been a boon to parents to know the diseases at the earliest and to arrange for its eradication. Mid-term evaluation report has high lighted improvement in all the above activities. Final evaluation has been over and we are awaiting the report.

III. HIGHLIGHTING OF ACHIEVEMENTS AND FUTURE PLANS: From the start of activities by the society in the year 1979, we have been concentrating on two fields: (a) Health: The nearest Government Institution from this locality is away by 16 kms. Opening of out patient clinic with in reach of the poor, as well as out reach programmes have been well appreciated by local population. We have been with them for more than 12 years. Our advice usually gets maximum considerations. They reciprocate their goodwill by their own voluntary help towards our organisation. (b) Introduction of PVOH-I Scheme in 1985 increased our health activities manyfold and the activities are still being continued. There were overall appreciation by the public as well as Government agencies towards the same. (c) We are glad to state once again that we have fulfilled all our committments towards PVOH-I Scheme. (d) Education: Started with lowest classes, grown upto matriculation level, education being made within reach of ordinary family, since the fees for the deserving. (e) Being a society we are not interested in profit making activities. (f)In addition to health and educational activities we established Indian Red Cross Society, Tamil Nadu Branch, Sub-Centre at Athipet and with the help of our volunteers we have done lot of relief work in the form of drought relief (200 people fed one meal daily for three months in 1985), distribution of large quantities of wheat, rice, oil, old cloth, etc., during emergencies like fire, flood, drought - all these by the help of Tamil Nadu Red Cross. A bore well has been put up for supply of

NEW CENTURY WELFARE, MADRAS
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drinking water to the needy during drought, in 1988 at Athipet. We are also running two creches for the past three years for the benefit of poor working class people. (g) Overall objectives: 1. To enlist professional and other volunteers towards welfare activities. 2. Maintain coordinated efforts with local, state and central Govt. agencies. We would go to the extent of doing our best towards achieving the objectives of the Governments. FUTURE PLANS: (a) Close cooperation with Governmental and International agencies. (b) carry out whatever activities presently being done with in our means. (c) Expansion of activities in new areas and new fields as well as in the same area. (d) We have the expertise, and capacity to fulfill our objectives. (e) We look forward in taking up new projects.

IV. (a) IMPORTANT LESSONS LEARNT FROM THE ACTIVITY: 1. There is a great necessity for voluntary efforts to coordinate with Governmental agencies for amelioration of peoples' distress. 2. Sincere and honest efforts involving local population will go, a long way in fulfilling the objectives. 3. PVOH-I Scheme are of great benefit to the poor. 4. Health activities need continuation for long periods, since the objectives are not fulfilled completely. This should be given consideration in future plans as well as PVOH-I Scheme. 5. Projects being temporary, efforts should be made to get sincere and hard working Doctors, paramedicals as well as other staff with high pay and added remuneration. This is likely to induce them stay for long periods for continuity. 6. The dibursement of finance should be very timely and allocation of cost. 7. Monitoring/Evaluations - the Government agencies have done their best - guided societies to fulfill their objectives.

IV. (b) 1. The voluntary organisations agreed to carry on, a substantial portion of the PVOH Grant activities even after Sep. 30th 1990. 2. Probably those who formulated the project did not visualise that what this project, needs is continuity. 3. It should be given consideration for the present scheme as well as future schemes. 4. With PVOH Scheme our activities have increased many fold. 5. The financial strain on the organisation will be so heavy that we may not be able to sustain it for long. 6. Naturally the activities has to shrink and it may not go well with the public, since we will have to continue facing them even after September 1990.

NOOTAN BHARATI,MADANA-GADH,GUJ.
P.V.O.H. PROJECT OF GOI/MOHFW

WRITE-UP FOR THE WORKSHOP UNDER THE AUSPICIES OF THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT, NEW DELHI

ACTIVITIES OF NOOTAN BHARATI UNDER PVOH-1 GRANT

I. BRIEF HISTORY OF THE ORGANISATION:

1. FOUNDATION OF NOOTAN BHARATI: 1st March, 1958. It was registered under the law as a Society and as a Trust in 1958.

2. OFFICE BEREARS: PRESIDENT: Mr.G.G.MEHTA, B.A.(Hons), LL.B., Barrister-at-Law, Advocate & Solicitor, MANAGER: Mr.RAMJIBHAI PASVABHAI VAHORA, Snatak, Gujarat Vidyapith, Ahmedabad and founder of Nootan Bharati, PROJECT OFFICER UNDER THE U.S.AID PROJECT: Dr.KANUBHAI RAMJIBHAI VAHORA, M.B.B.S.

3. 'CHANGE OF HEART' THEORY IN PRACTICE INSPIRED BY GANDHIJI:

(i) MAFIAS: For several years, before and after foundation of NOOTAN BHARATI, forcibly carried away ripe crops of farmers and harassed women. Mr.MEHTA and his wife undertook a fast-unto-death with the result that on the 7th day, the mafias apologized to him and took to their original agricultural occupation.

(ii) PROSTITUTES: In a prostitutes' village, Mr.MEHTA undertook a fast for 7 days, when the prostitutes took vows to give up their profession and resorted to agriculture on Government donated lands, admeasuring about 200 acres.

4. AGRICULTURE: Mr.RAMJIBHAI, a farmer, demonstrated crops produced through modern methods in 52 acres of Nootan Bharati lands donated in BHOODAN. They were successfully adopted by the farmers of 60 villages populated by 100,000 people covered by the organisation for its multifarious constructive activities.

5. AN IDEAL FOREST: known as Ravivan, was organised with about 10,000 trees, including equalyptus, baval, subaval,boradi, etc.

6. COW-REARING: The organisation also developed through Cross-Breeding ideal breeds of cows and bullocks of Kankareji, Jarsi, and H.F.(Australian) breeds, now adopted by most farmers.

7. EDUCATION: Nootan Bharati followed the principles of Mahatma Gandhi, suitable to Indian village conditions, for its educational activities. It is running (1-2-3)K.G., Primary and

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Secondary education Classes, (4) a College for the degree course of B.R.S. (Bachlor of Rural Studies) and (5) Adult classes.

8. INDUSTRIAL TRAINING INSTITUTE (I.T.I): Nootan Bharati is running I.T.I. Classes of (1) Wireman (2) Fitter and (3) Draughtsman Civil, for solution of unemployment and poverty.

II (a & b) : ACTIVITIES THROUGH THE PVOH GRANT INDICATING CHANGES IN HEALTH INDICATORS:

1. THE U.S.AID PROJECT: Nootan Bharati has, for a period of 4· (extended to the 5th year), incurred an expenditure of Rs. 2,693,932 increased to the total of Rs.3,358,708 (25% shared by Nootan Bharati) and 75% received as grant under the Project sanctioned by the Government of India.

2. CENTRES OF THE ACTIVITIES: The Central Office of the organisation under the PVOH grant is set up in the main campus of Nootan Bharati at Village Madana-Gadh in Taluka-Palanpur, District-Banaskantha, Gujarat State, where a hospital of 10 beds is set up as approved by the authorities concerned. Three Sub-Centres are set up in the village with 10 or 11 villages covered by eacn Sub-Centre for immediate medical services and live contacts with the rural people in 31 villages with 60,000 people.

3. TWO AMBULANCES: Nootan Bharati purchased 2 Jeep cars turned into two Ambulances at its own cost of Rs.264,568/87. One of them goes every day to a village to provide medical services to the rural people at their door-steps. The other ambulance is used for propaganda to avoid diseases, by showing films, cassettes, discussions at meetings of village leaders, etc.

4. LIVE CONTACTS WITH EVERY HOUSEHOLD: The staff of the three Sub-Centres looks after the people of 10 to 11 villages each.It maintains a detailed survey report of every village and cultivates live contacts housewise with rural people including students in Schools. Thus, it is albe to treat all patients-men, women and children, young and old for solving immediate and long-term health problems.

GREAT PROGRESS, ELOQUENTLY PROVED FROM FOLLOWING FIGURES:

FACTS AND FIGURES OF MEDICAL ACTIVITIES AND ACHIEVEMENTS:

COMPARATIVE STUDY OF THE PROGRESS:

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SR. NO.	ITEM.	POSITION PRIOD TO COMMENCEMENT OF THE PROJECT.	PRESENT POSITIONS AFTER 5 YEARS.
1.	O.P.D. Attendance (average):	52/per day	85/per day
2.	Birth Rate:	35.6	25
3.	Death Rate:	18.97/1000	11/1000
4.	I.M.R.:	132.5/1000	100/1000
5.	Percentage of pregnant mothers given T.T.:	1 %	85 %
6.	Couples' protection rate:	30 %	50 %
7.	Percentage of deliveries under Dr./Trained persons:	35 %	75 %
8.	Percentage coverage of D.P.T:	30.1 %	90 %
9.	Percentage coverage of Polio:	30 %	90 %
10.	Percentage coverage of B.C.G:	34 %	90 %
11.	Percentage coverage of Measles	0.0%	50 %
12.	No.of Handicapped persons benefitted :	--	239
13.	No.of people got benefit of the Eye Camp:	924	1926
14.	No.of Eye Camps organised : Major	4	9
	Minor	22	22
15.	No.of General Health check-up camps organised :	10	31
16.	No.of T.B.Camp organised:	8	22
17.	No.of T.B.Petient taking treatment :	25/per month	162/ per month

PROGRESS FROM TARGETS AND ACHIEVEMENTS:

SR. NO.	TYPE OF SERVICE	TARGET	ACHIEVEMENT
(1)	ANTENATAL CARE:	--	9294
1.	No.of Antenatal Cases to whom Inj.T.T. & Iron Folic Acid given :	5602	8287
2.	No. of mothers to whom postnatal care given :	5692	8064
(2)	VACCINATIONS:		
1.	B.C.G.	7046	7600

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2.	D.P.T.:	7031	7031	
3.	POLIO:	7031	9255	
4.	Measles :	1970	2579	
(3)	HEALTH EDUCATION:			
1.	No.of Group Meetings organised:	250	650	
2.	No.of Mass Meetings organised :	141	130	
3.	No.of Individual Contacts :	24031	74260	
4.	Exhibitions organised :	35	156	
5.	Film shows :	337	474	
6.	Posters/handbills distributed:	--	5000	
7.	Talks on environmental sanitation practices :	95	376	Meetings
			70	Exhibitions
			135	Films
			14	Kathas,Kirtans Bhajans.
(4)	ENVIRONMENTAL SANITATION:			
1.	Construction of community toilets	--	850	
2.	Construction of soakes pits.	--	118	
3.	Construction of smokless Chulas	--	414	

III. MAIN OBJECTIVES: NOOTAN BHARATI'S overall objectives are to extend health services and to acquire all-round uplift of the rural people, including solving their health complaints and also unemployment, poverty, illitracy, social and other problems

IV.(a) LESSONS LEARNT FROM NOOTAN BHARATI'S ACTIVITIES: The most important lesson learnt by Nootan bharati and its dedicated workers, numbering about 193, from our above activities is to follow the message of Mahatma Gandhi to " DO OR DIE " to build up a healthy happy and live rural India, as adopted for attaining the freedom of India from the slavery of the British Empire.

IV.(b) PLANS TO SUSTAIN ACTIVITIES AFTER SEPTEMBER-1990: To sustain our present activities after September 30, 1990, we propose to adopt the Schemes on Health of the State Government and the Union Government and also those of the U.S.AID Organization and other organisations in Indian and outside India, such as, UNICEF, Consciousness International Foundation,Canada, etc.

MADANA-GADH.
DATE:14-7-1990.

Dr.K.R. VAHORA
PROJECT OFFICER
NOOTAN

R.P. VAHORA
MANAGER
BHARATI

G.G. MEHTA
PRESIDENT

(Assisted by the U.S.A.I.D.)

SARVAJANIK P.K. & S.S., GWALIOR
P.V.O.H. PROJECT OF GOI/MOHFW

"Sarvajanik Pariwar Kalyan and Sewa Samiti, Gwalior(MP) established in 1965 is a voluntary social registered organisation.

COMMUNITY AND TERRAIN OF THE P.V.O.H. PROJECT AREA

The Organisation had taken up "Basic Health, Family Welfare, Nutrition services, Training and Research Project" to cover 34 most backward villages of Gwalior district. The Project assisted by USAID under PVOH scheme of the Govt. of India, was started in April 1984. The total population under the Project area has been about 20,000 out of which 93% belong to the Schedule Caste, Schedule Tribes, backward classes and economically down-trodden who are living below the poverty line. There are three rivers and about 49 small rivulets. The terrain of the Project area is mostly hilly where means of transport and communications are extremely difficult. During the rainy season it was almost impossible. In fact the Project area is a vast expense of open land, full of thick jungles, wild animals and poisonous snakes. Besides the project area is dacoit infested. The people living in the area are extremely poor with no means of livelihood except being marginal agriculturists without any facility of irrigation or any other means of livelihood.

In the project area there is hardly any means of inter-communications. Only footpaths are there that are fully destroyed during the rains. Thus no health services could be reached to the people of the villages. Whatever health institutions are there they are at such a long distances that the rural inhabitants could not avail of any advantages from these. As a result prior to 1984, when the Project was implemented, the villagers usually fell victims to diseases like Diarrhoea, Dysentery, Cholera, Typhoid, Respiratory diseases, intestinal parasites, Malaria, Jaundice, T.B., eye-diseases and different skin infections. Along with these babies were born with low weight and sometimes had birth injuries. In the natural course facilities for ante-natal, post-natal and child care could hardly be made available to these people with the result that infants death rate was very high. In the same way maternal deaths were quite frequent because no proper medical care could reach to them. Preventive measures such as immunisation could hardly be made available to them. As such incidence of Dyphtheria, whooping cough, tetanus, T.B. was very prevalent.

The village people had to depend on the wells unchlorinated water because there was no arrangement for Chlorination of water in the villages and as a result of it they suffered usually from many common infections and other water borne diseases.

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Keeping all these in view the Project had taken up the working with the following broad objectives :

a) To carry out survey and collect data on various health and related problems viz, IMR, Pattern and rate of morbidity, CBR, CDR etc.
b) To provide preventive, promotive and curative services at the very door steps of the people.
c) To encourage people to drink safe and pure water and to store it well and purification of village wells for drinking water with bleaching powder.
d) To organise campaign against prevalent diseases in the project area.
e) To improve services and techniques of indigenous mid-wives in the Project area.
f) To develop an effective Ante-natal, natal and post-natal care system.
g) To provide and improve status of nutrition of children and mothers.
h) To raise the level of awareness, knowledge about health consciousness, sanitation, immunisation among the people of the community, particularly the adults and school-going children.
i) To expand facilities of health education and training of the various groups of community, particularly the mothers.
j) To provide family welfare advice and services to the largest group of the people.

IMPLEMENTATION METHODOLOGY

To achieve the stated objectives, the organisation has been providing services through a two-tier structure mainly the main services and Coordination centre located in village Sahona (also known as Sahona hospital) and health posts. The various infrastructure proposed to be created under the project including construction of main services centre at Sahona and establishment of five health posts, purchase of equipment and vehicles, training of project personnel etc. were all completed by the organisation within the given time. The building construction work was a herculean task because there had not been any road (Kutcha or Pucca, motorable or non-motorable) linking Sahona with the nearest metalled road as such the building material had to be brought to site by bullock carts only.

The village health posts (presently three) located in villages Kaithoda, Sakatpura & Jargaon are manned by one male and female health worker, are acting as platform disseminating basic health care facilities to distant locations. The distance on an average, of these health posts from the main centre (Sohana) varies between 12-25 kms. or so.

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The main coordination and service centre located in the project HQ.at Sahona houses OPD, indoor facilities (6 beds) pathological laboratory, minor OT, labour room, including community centre. It also houses administrative block as well as space for patients waiting and dormitory for training purposes. The centre remains open on all the seven days of the week, providing services for 4 hours in morning and one hour in the evening. The emergency services are made available round the clock, by virtue of the Medical Officer and other health staff being living in the hospital complex. The main centre receives referral cases from the different health posts or even directly from the villages. These referral cases are usually of accidents, Gynaecological problems, diarrhoea etc. The centre also refer the serious cases to the other specialised hospitals and follow them up.

The Village Health posts open on all the days of the week providing services for six hours a day. However,the emergency services are made available throughout by virtue of the fact that the health staff had their residence in the Health Posts compound. The services of the staff are so effective because the staff of the village health posts, and the main centre have all been recruited from the village areas of the project and their services reach to the very doors of the villages.

SERVICES PROVIDED BY THE PROJECT

The following services are being provided by the Project :-
Preventive & Curative services, Antenatal, natal, Post natal services, treatment of chronic diseases, Routine Laboratory investigation, immunisation, child growth monitoring, FP motivation, Distribution of Iron Folic Acid Tablets, Vitamin A solution, Chlorination of wells, distribution of supplementary nutrition to mothers and children, Health and Nutrition education, home visits, Campaign for ORT, group meetings, mass meetings, exhibitions, film shows, Orientation camps etc. Besides, talks are arranged on environmental sanitation practices, construction of low cost toilets, smoke-less chulhas, garbage disposal, composit pits, and guidance is provided to the village people. They are also told about better home management, proper storage of water and food and its protection from mosquitoes, flies, dirt, are also explained to them along with the way it is done. Thus the Project has been able to gain remarkable success in gaining advantages and safeguards for the people who had been suffering from them prior to the implementation of programme by the Project staff who belonged to the villages of that area.

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ACHIEVEMENTS OF THE PROJECT AT A GLANCE

1) Reduction of 60% in the diseases that were prevalent in 1984 prior to Project implementation.
2) Regular Chlorination of cent-per-cent village wells has reduced infections and water borne diseases to 70%.
3) Benefit of 75% immunisation of children due to cent-per-cent growth monitoring registration.
4) 75% of the ladies benefitted by Antenatal, natal and postnatal services.
5) 80% mothers and children distributed folic acid & iron tablets. 75% of children provided Vit. A solution.
6) 45% target-couples benefitted by different family planning methods.
7) The houses of all the villages have been registered and put the numbers C.P.T.F. on the doors of each. This has been done in cent-per-cent cases. The term explains that C stands for the child living in the house less than a year, P means there is pregnant lady in the family, T shows that there is target couple and F shows that in the family there is a member who follows F.P. methods.

COMMUNITY PARTICIPATION/IMPORTANT LESSON LEARNT

Cooperation of the community is solicited in every stage of activities. The people have been taken to participate in village level, village health posts, main hospital level and supervisory level in the form of different committees. In all the activities of the Project from Planning, Monitoring, Implementation, and Coordination their active cooperation has been solicited. The most important lesson the organisation has learnt from the working of the Project is that unless we enlist active cooperation of the community and take the workers from among them our success can not be as much as we have gained.

SUSTAINABILITY OF ACTIVITIES

Sustainability is a problem without any grant-in-aid. The reason is that there are no susbstantial resources with the organisation. Contribution from the area people is not expected as they are very poor and no contribution can come from them. Therefore, grant-in-aid is necessary to run the project effeciently. Even then, the health workers, being local people, who can do something for the project as a part of their cooperation shall do something and thus we shall manage it as we possibly can.

(Dr. B.S. VERMA)
Secretary

Sarvajanik Parivar Kalyan & Sewa Samiti, Darji Oli, Gwalior (MP) Phone: 25419

(Assisted by the U.S.A.I.D.)

SEVADHAM TRUST, PUNE
P.V.O.H. PROJECT OF GOI/MOHFW

THE TRUST

Sevadham Trust is a Public Charitable Trust engaged as the name implies in service and welfare activities for more than a decade. The Trust's activities now encompass many a fields related to **'Human Development'**. No wonder the Trust is actively involved presently in Health care planning and development, Non-formal Education,Women and Child Development, Upliftment of Tribals, Rural Development,Training of Health and Development workers and Research in Health Sciences. The Trust has been accredited by Govt. of India for its innovative approaches in health education and honoured the Trust to host Health Education Conference in Collaboration with Ministry of Health and WHO. Forhis dedication and selfless services the Managing Trustee Dr.S.V.Gore was felicitated by the Government of Maharashtra with the title of **'Advasi Sevak'**

THE FOCUS

Our main focus of action has been the rural tribal community residing in 24 inaccessible backward villages of Ander Maval area of Pune District, which is nearly 20 Km. on the North of Pune Bombay Road from Wadgaon. It represents the Western hilly wet zone of Maharashtra upland. The typical geophysical conditions existing in the area result in population being scattered. Heavy monsoon literally cuts-off this area from remaining world during rainy season. Communication means are to say the least bad. Most of the area is hilly and undulated. Difficult geographical condition had deprived the population of benefits of advancement of science and technology.

Illiteracy,superstition,apathy,fatalistic attitude together with extreme poverty used to take heavy toll in terms of preventable morbidity and mortality. The health care services were patchy, occasional and seasonal and the peripheral health care functionary was hardly available during the need-hour.

THE PROJECT

Realising the above fact the Trust embarked upon its multipurpose workers project in 1985 with the help of Govt.of India and USAID. The project caters to the health needs of 22000 population spread over in an area of 450 Sq.Km in numerous hamlets. **'Wadeshwar'** is selected as the headquarter of the project since major part of the difficult terrain lies around it. It has a small Maternity and Child Health Centre with provision of 16 beds. It is the nucleus through which the primary health care activities radiate in the periphery. The villages are grouped into seven subcentres, each equipped with a sub-centre, building for organising effective health care delivery. Trust's hospital

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SEVADHAM TRUST, PUNE
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at Talegaon acts as a referral hospital, since it is equipped with specialist services.

To start with, multipurpose workers were selected from local community and were given 6 months training in the tasks they were supposed to perform. Frequent re-orientation training courses and prompt back-up services helped the workers in improving their knowledge, skills and credibility, which reflected in their actions. Impressed by the enthusiasm of workers and dedication of Trust, Zilla Parishad,Pune vide its resolution No.1261/87 handed over the villages to the Trust for health care delivery. It is for the first time in the state that a voluntary organisation was entrusted with such responsibility by the Zilla Parishad.

HIGHLIGHTS

Last few years have witnessed a progressive remarkable change towards preventive and promotive health activities. Availability of continuous and assured health care services within the easy reach, improved its uptake. The project always exceeded the targets alloted by District Health Office for various health care activities.

Almost cent-percent registration of antenatal cases, with minimum of three follow up visits to each and 80% tetanus toxoid to pregnant women against almost 'Nil' activities before 1985, are the hallmark of the project.

Out of total deliveries during the project period 4% were conducted at health centre, 2% by project staff at home and remaining by the dais, trained at Wadeshwar.

Seventy percent of the mothers were followed up during postnatal period with an average of two visits each.

An overwhelming response was evidenced for immunisation. The change was right from resistance to active participation and demand generation. The phase went through the stages of relunctance and passive participation. DPT and Polio coverage was more than 85%, BCG and Measles coverage was approximately 10 and 15% due to technical and logistic difficulties.

Of interest was the discernible change in the attitude of people. Superstitions were being gradually replaced by reson and scientific approach, apathy by concern and participation and fatalistic attitude by will and confidence for change, translating into demand generation.

On environmental front, Concept of Gobergas Plants, Smokeless Chulhas, Glass Tiles for kitchen roofs and plantations, was introduced and well taken.

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INNOVATIONS

Right from the beginning the Trust endeavoured to change the health need to felt-need and hence geared the health education approaches accordingly. The emphasis was on making use of religious sentiments and customs and studying and using their ways of communication. The innovative approaches adopted by the project were appreciated at all levels and were replicated by others with rewarding results. The cultural troup formed by the Trust for carrying out health education activities is frequently invited by govt.of Maharashtra for health education and development training through entertainment. The troup is receiving wide acclamation not only from all over Maharashtra but the country too. Sr.Media Offiers of Four Northern States and Maharashtra were deputed to stay and observe the innovative ideas implemented by us for Health Education.

In appreciation of our health education activities the Media department of the University of Pune in collaboration with the Penicilvania University (USA) organised filming of the activities which went on National T.V.net work.

A STEP AHEAD

Since the project was time bound flow of funds was discontinued after January 1989. Unavailability of funds forced the Trust to retain bear minimum staff for carrying out health care activities. The Trust then expressed its inability to organise the services exclusively. Consequently Zilla Parishad,Pune took over the charge of the area again.

Experience of four years made the Trust to redesign the health care project which was then implemented during extension period. Constraints in terms of funds, health care service availability and uptake were the key factors behind re-designing. The situation made the Trust to launch a 'Link Workers' project in the area. The concept is based upon improving the health care uptake, participatory approach and community financing leading to self-dependency.

One link-worker was identified for every hamlet/locality. Functional unit for link workers was thus not the village but the hamlet. Thus for 24 villages 38 link workers were identified. Earlier trained workers were given priority during selection. All the workers underwent one week training programme. The training programme was residential and participatory in nature. On completion the link workers started work in the field with support from four supervisors, extension educator and Project Director along with Medical Officers.

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TRIBAL RURAL LEPROSY ERADICATION SCHEME

Early detection and eradication of leprosy has been entrusted to us for complete tribal belt of Pune District comprising 165 villages withdrawing Zilla Parishad staff.

HEALTH : AS A PART OF TOTAL DEVELOPMENT

Believing in the decisive role of education in maintenance of health, the Trust runs 19 Nursaries, 50 Non-formal Education Centres and special coaching programme for Tribal school children. In addition seminars of tribal youth and women and unorganised labourers and farmers, in collaboration with the Tribal Department and The Workers Education Bureau were also organised. Trust is starting job oriented training, income generating programme, poultry farming and Multipurpose Co-operative for the tribals. Training programmes in development planning of villages were recently organised.

THE LESSONS LEARNT

* Health cannot be viewed in isolation and has to be an integral part of total development.
* Activities pertaining to development, imbalances whatever the existing power structure be and evokes antibodies, since the interests of power structure are at stake.
* Self reliance in health care cannot be complete as long as general population is poverty sticken. The concept needs to be evaluated especially on the background of extreme poverty of the community. External financing is essential for longer duration.
* Health Education and securing community participation should be the major role of voluntary agencies in effect moulding and activating the Government infrastructure to yield desired results.
* As more than 80% deliveries in rural areas are conducted by traditional Dais, it is essential to train them thoroughly.
* House hold chlorination of drinking water daily, proves to be cost effective and most promising way for intercepting water borne diseases, as seen in our trials.

PLANNING FOR SELF SUFFICIENCY

Stress on Socio-Economic projects, collective responsibility, community financing and support by state; in March towards self sufficiency.

(Assisted by the U.S.A.I.D.)

SIDHU KANU GRAM UNNAYAN SAMITI
P.V.O.H. PROJECT OF GOI/MOHFW

ON THE PROGRAMME AND THE ORGANIZATION: The programme was conceptualised as an Operations Research (OR) to evolve a systems-analysed Model for a participative health-management system and to test its replicability viability through multi-focal trials at the national level. The programme design was based on a successful and field-tested pilot experiment carried out at Memari (Burdwan) with a restricted objective of diarrhoea-control in below-7 children, through the chlorination of water-store at the family-level. The purpose was to mobilise and motivate selected tribal family-groups for social actions involving the participative mothers in that experimental exercise for the preventon of diarrhoea in children. With funds from the UNICEF, a three-year follow-up study (implemented through the leadership of Sidhu-Kanu Gram Unnayan Samiti (SKGUS) - a social action platform for the local community) on 600 families demonstrated the dependability of chlorination of drinking water at the family-level as an effective control-system against endemic diarrhoea in children.

The area and the action-groups were identified during the devastating flood in the district of Burdwan in 1978. They participated in the relief-operation during the flood and in the post-flood rehabilitation of heavily affected families. These field-tried action-groups formed the core organizers for the organization (SKGUS), which was registered in 1980-81. Since then the Samiti started operating as social change-agents with funds from the national and the international donors.

ACTIVITIES & ACHIEVEMENTS UNDER PVOH-I: The activity-pattern under the PVOH Phase-I was specifically designed around Mother-and-Child care with a special reference to the effective care of pregnancies in poor families and of the infants born, through their vulnerable years. The modality of operation was mother-based, motivated and directed by family-level volunteers (FLVs) who were coordinated and supervised by the village-level workers (VLVs). These VLVs were guided by a core of multi-purpose health-workers (MPHWs, one male and one female per 10 12 villages) and the MPHWs were coordinated by a Programme-Co-ordinator cum Pharmacist. The doctors under the project's structure provided the professional guidance/services.

The 60 villages under Memari Thana covered by the Phase-I are scattered in two Development Blocks (Memari I & II). The area is connected through two highways with Burdwan, about 25 Kms away from the project's Headquarters. Burdwan town hosts a University with a Medical College and other faculties and is one of the busiest rural trade-centres in the State. Communities covered under the Phase-I programme include Adivasis (60%) and the rest from Scheduled Castes, Muslims, and poor Hindus. The purpose of retaining a high proportion of Adivasis was to streamline Do's and Don'ts for an effective implementation of the programme-parameters.

The activities under the programme were officially evaluated in September, 1989 and the summary of randomly sampled findings indicates the level of success in the area of participative health-care systems, activised by the FLV-VLV axis, coordinated and supervised by the second tier of para-professionals, professionally guided/served by the third tier of doctors. The table below indicates the status:

(Assisted by the U.S.A.I.D.)

Services	Status at initiation project-period (%)	Target set for the evaluation (%)	Coverage revealed by (%)
1. Antenatal registration	<40	100	88
2. Delivery at Institutions/by trained Dais	<30	80	82
3. Post-natal contacts made within <15 <30 days	Not available	Not set	91
4. Immunization			
TT for mothers	53	100	87.4
DPT (3 doses)	25-27	100	86-100
Polio (3 doses)	23-24	100	85-100
BCG	10.6	80	89.6
Measles	Not available	Not set	66.0 (i)

(i) Measles vaccine was introduced nearly two years after the initiation of the PVOH-programme.

PROCESS, PROGRESS AND PROJECTION: The primary emphasis has been on the training of mothers in the management of child-health and on preventions/remedies for common community-sicknesses. The participative modality of implementation at the rural grass-roots could effectively provide the preventive measures for the control of common maladies, in full compliance with the national health-objective. And, this has been possible because of educating the mother-volunteers (one per 25 families) through a training-schedule of six months and at the end of the schedule the trained being replaced by a fresh batch of untrained mothers. The cycle repeated in these four years could create the critical herd of informed mothers, trained on the basic items in health-care.

The training schedule covered 20 topics which include amongst others, the values of immunization against nationally identified diseases; diarrhoea and its control; safe pregnancy and the mechanism of its surveillance; social hazards/free treatment of tuberculosis/leprosy: their respective controls; the prevention/treatment of night blindness with Vitamin A; sanitary toilet habit; effective disposal of organic wastes and water etc. How much the mothers could retain these informations and how many of these are being practised have also been monitored by the evaluating team. Some socially relevant sampled data on proxy indicators have been summarised in the following table:

Proxy-indicators on progress	Percentile levels attained
1. Awareness on diarrhoea and ORS in therapy	75.5
2. Awareness on Need/Benefits of Immunization	93.6
3. Awareness on Safe drinking water	95.0
4. Awareness on Use and purpose of chlorination of drinking water	85.0
5. Awareness on small family norm	85.0
6. Awareness on spacing of child-birth	74.2
7. Adoption of one/other FP methods	77.0

The overall objectives through such activities have been to identify the limit of success which the people can bring about through their participative efforts and pinpoint the weak links in that management-network involving the people and the professional services. The future plans are being designed to meet these shortfalls for ensuring the total success of the OR as conceptualised for the formulation of a replicable Model. The future tasks include i) the recognition of essential inter-links of health-related and associated/allied multi-sectoral inputs, ii) development of rural resources, and iii) evolving effective management-nexus, facilitating the integrated operation by utilising the ones' outputs as inputs for the other, aiming at a holistic totality in outcome benefits and the sustenance of the process.

LESSON LEARNT AND PLANS FOR SUSTENANCE OF THE MECHANISM EVOLVED: Three important lessons of the MEMARI experiment carried out with the support of PVOH-Phase-I are:

i) The rural poor can operationalise their own commitments on participation and surveillance for the management of the basic "Health-care" systems at the rural grassroots, provided of course the cost-intensive professional inputs and the physical infrastructure required for the distribution of services are made available to them;

ii) The situational compulsion demands that these inputs must be appropriately engineered by drafting the professional training institutions (eg Medical Colleges) or the resources available under the official structure for providing those professional inputs and transferring the outreach Sub-centres to the people's management for providing the structural base in that self-management Interface System. This

process in return will ensure effective teaching/training programmes for the professionals within the concrete frame of rural realities and a better utilization of currently non-functional Sub-centres as Interface institutions/centres for rural development operated by the people for their self benefits.

iii) For the quality-quantity transformation of distributive macro development in order to enrich the community-life at the rural micro world, people must understand the dynamics of rural miseries. And for the effective management of that "Inducer" mechanism of Transformation at the Interface, the generation of complementary rural resources (in men, means and materials) at the disposal of the people and upgrading the motivational awareness for the development of appropriate need/demand-sense in the rural communities are absolute necessities. This can only be achieved through an exercise interlinking the health-related and associate/allied multi-sectoral inputs in the participative management-nexus for the holistic outcome benefits.

The plan has been drawn to operationalise these essential dimensions, like, drafting the resources of Burdwan Medical College and other co-lateral professional expertise available with the Burdwan University as well as involving the existing sub-centres within the frame of the Interface structure. The coordinated "HOLISTIC" approach in the integrated Management-by-Objective (MBO) will also be streamlined with multi-sectoral inputs in education and development - available under various governmental programmes.

The triangular management-network between the people's organized efforts, the teaching/service centres and the multi-sectoral inputs for the holistic gestalt will be synchronised and systemised during the second phase of the societal experimental at Memari. The success of that experiment will determine the sustenance of the Model.

A draft proposal to that effect as outlined above has been submitted for fund support under the PVOH-Phase-II scheme.

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SIVAGIRI SREE NARAYANA MISSION
P.V.O.H. PROJECT OF GOI/MOHFW

INTRODUCATION

Sivagiri Sree Narayana Medical Mission hospital situated in Varkala, Trivandrum District, Kerala State is established in Varkala in the name of the Saint Sree Narayana Guru, who preached the gospel "one caste, one Religion and one God". It is a hospital owned by the Sree Narayana Dharma Sanghom Trust, Sivagiri, a charitable trust founded by Sree Narayana Guru. The trust is a body consisting of Sanyasins and is registered under Regulation 2 of 1088 (Malayalam Era), the object of the Trust being to do service to humanity, to perpetuate the monastic order of the members, to hold and administer and develop institutions such as mutts, Temples and other religious and charitable institutions like hospitals, schools etc: This Medical Mission hospital was started in the year 1952 as a small unit with minimum conveniences and with meagre resources. Since then the institution has grown up into a major hospital in this part of the country with 224 beds and with almost all the specialities of a modern hospital. The hospital is run on philanthropic basis without any profit motive and it renders service to the general public without any distinction of religion, caste, creed or colour.

TARGET AREA, POPULATION ETC: OF THE PROJECT

In January 1987 the Government of India sanctioned a three year health project to this Medical Mission with a total outlay of Rs.74,21,000/- or which Rs.55,65,000/- would be grant in aid and Rs.18,56,000/- would be contribution or the organisation. The places identified for the implementation or the project are located in Thrikkovilvattom and Kalluvathukkal Panchayats in Quilon District and Navaikulam Panchayat of Trivandrum District, where health service facilities are not available or where the facilities available are inadequate to cope with the public demand. The population of the rural areas selected for the project are mainly agricultural either being small holders of land or agricultural labourers. The project envisages the opening of one Rural Health Centre and three Mini Health Centres in Thrikkovilvattom Panchayat of Quilon District to cover a populatin of 40,000, two Maternity & Child Welfare Homes in Kalluvathukkal Panchayat or Quilon District with a coverage of 20,000 population and two Mini Health Centres in Navaikulam Panchayat of Trivandrum District to cover a population of 10,000. The Sivagiri Sree Narayana Medical Mission is to function as the Base Hospital or the main referral centre. The Thrikkovilvattom Panchayat is

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thus to have a three tier system consisting of Mini Health Centres Rural Health Centre and the referral Base Hospital. The Maternity and Child Welfare Homes in Kalluvathukkal Panchayat are to be directly under the medical supervision of the base hospital and the two Mini Health Centres in Navaikulam Panchayat are to be directly under supervision or base hospital project management and hence these two panchayats are to have a two tier system. The Rural Health Centre is to have two Medical Officers (one male and one female) with a complement of para medical and other staff and this is to function on a par with the Primary Health Centre of the Health Services Department. The three Mini Health Centres in Thrikkovilvattom Panchayat are to have one A.N.M. each and the centres are to be under direct supervision of the Medical Officer of Rural Health Centre. The Maternity and Child Welfare Homes are to be under charge of two A.N.Ms each and the Mini Health Centres in Navaikulam Panchayat are to be under charge of one ANM each and these units are to be supervised by the Medical Officer of the base hospital.

OBJECTIVES OF THE SCHEME

The general objectives of the project are, (a) to improve the health conditions of the people in the area, (b) to improve the medical care of the people in areas where such services are not available or inadequate, (c) to focus on preventive aspects including immunisation, health education, sanitation and malnutrition, (d) to orient women volunteers from each village (50 in number) about health, nutrition, family welfare, hygiene and environmental sanitation to enable them to play their role as change agents in the villages, (e) to create local voluntary organisations with skill and capacity to manage general welfare of the village communities.

The specific objectives are to achieve by the end of 3 years (a) Immunisation of pregnant women, infants and children(TT, DPT, DT and Measles) 85%, (b) Registration of pregnant women 85%, (c) Antenatal examinations during pregnancy(minimum) 3, (d) Delivery by trained personnel 85%, (e) Health check up of school children 80%, (f) Couple protection through family planning 60%.

TRAINING AND HEALTH EDUCATION

The project scheme also contemplates organisation of health education camps to impart health, nutrition and family planning education to the community at the grass root level in villages comprising the Mini Health Centres. Each such camp is to have 50 women volunteers as participants and the subjects on which health

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education is to be given to the volunteers consist of antenatal and postnatal care, importance of immunisation, breast feeding weaning practices, control of diarrhoeal diseases through ORT/ ORS, hygienic and environmental sanitation, symptoms and detection of T.B. and leprosy, need for maintaining small family and use of contraceptives etc: so that they may act as change agents in society.

OPENING OF PROJECT CENTRES

By June-July 1987 all the centres were opened at places approved by the Government. Soon after the opening of the centres the staff as per pattern approved were posted to the various centres. As a first step the baseline survey contemplated in the scheme was conducted. The A.N.Ms of various centres collected the required data by house visits under supervision of the Public Health Nurse and Lady Health Visitors and these were analysed and the baseline survey report was prepared. The survey showed that the total population of the area allotted for the project is 44317 of whom 22532 are males and 21785 females and that the total number of households in the area is 8119. The survey also showed that the population of the area covered by the project is predominantly low income group and at the sametime the percentage of literacy is very high. It also indicated that the percentage of people with awareness of the need for family planning in the area is very high and that there was need for boosting immunisation services.

SERVICES PROVIDED

Services provided in the project centres consist of preventive, promotive and curative. Immunisation of pregnant women and children, distribution of Vitamin A and Iron & Folic Acid are done as preventive services. Antenatal, natal and postnatal services, family planning services, orientation training, health check up of school children are done by way of promotive services. Curative services are provided in the nature of outpatient and inpatient treatment.

Till the end of June 1990, 1115 first dozes, 1000 second dozes and 127 third dozes of TT were given to mothers. The number of cases in which BCG was given to children upto June 1990 is 1146. DPT to children, 1845 first dozes, 1870 second dozes, 1899 third dozes and 729 booster dozes. The number of cases in which oral polio was given is 1828 first dozes, 1910 second dozes, 2073 third dozes and 1146 booster dozes. The number of cases in which Measls injection was given upto June 1990 is 870. 1570 first dozes,

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986 second dozes, 461 third dozes and 76 fourth dozes of VitaminA were given to children till the end of June 1990. 2644 first dozes, 2517 second dozes and 2492 third dozes of Iron and Folic Acid were given to mothers till June 1990. 2170 first dozes, 2065 second dozes and 1894 third dozes of Iron & Folic Acid (small) and 584 first dozes, 472 second dozes of Iron Liquid were given to children during the period upto June 1990. With regard to family planning the number of cases in which P.P.S was done in the area comprising the project is 1822. The number of I.U.D insertion is 56 and the number of condams distributed is 5720 pieces. O.P given to women during the period is 97 cycles. The total antenatal registration is 2601, antenatal contacts 6012, total births in the area is 1871, postnatal contacts 2370 and infant registration 3108. Regarding curative services, the total number of patients who have undergone treatment as outpatients is 43737 and the number of patients who have received treatment as inpatients is 661. The total number of children in primary schools who were subjected to health check up till 30.6.1990 is 1694. As for orientation training camps, the number of camps conducted till June 1990 was 66 and the women volunteers who participated in the camps number 3115. The project activities are in a progressive stage of implementation and are nearing the targets prescribed.

The response from the public is positive and favourable and taking this as an index it is felt that there is scope for continuing the services beyond September 1990. In the case of the two Maternity and Child Welfare Homes at Velamanoor (Pulikuzhy) and Ezhipuram in Kalluvathukkal Panchayat in Quilon District we have got 15 cents of land each surrendered by two local landlords for specific purpose of construction of health centres. So also in the case of the Mini Health Centre, Parakunnu in Trivandrum District we have taken possession of 10 cents of land - 5 cents by outright purchase and 5 cents by donation by the landlord. In the case of one of the Maternity and Child Welfare Homes viz, that at Velamanoor construction has reached plinth level, but the same could not be proceeded with owing to want of funds. Construction of buildings for the other two centres referred to also could not be taken up due to lack of funds. Paucity of funds is thus a stumbling block in the progress of construction of buildings for the project centres. We would however like to continue the services provided buildings for the various centres could be constructed and used for the purpose vacating the existing rented buildings.

(Assisted by the U.S.A.I.D.)

SRI RAMAKRISHNA ASHRAMA, TVM.
P.V.O.H. PROJECT OF GOI/MOHFW

The Ramakrishna Ashrama, a branch of the Ramakrishna Math and the Ramakrishna Mission, Belur, Howrah, West Bengal was founded at Nettayam near Trivandrum in 1916. The Ashrama started a small dispensary in the city at Sasthamangalam which has grown to a fullfledged General Hospital. The Ramakrishna Mission was established under the Public Trust Act and was registered with the Registrar of Assurance, Calcutta.

At present, the Ashrama has a 293 bed hospital of which 129 beds are reserved for the poor patients who are provided with medical care, nursing care and diet free of charge. The hospital facilities include a General OP, a Polyclinic, a maternity and child welfare department, a psychiatric ward, ophthalmology, ENT, Dental & Orthodontic departments, two major operation theatres, 4 X-ray units, ECG unit, clinical and biochemical laboratories, a critical care unit and a 24 hour casualty section.

The Ashrama also runs a three year GNM course with an annual intake of 20 students.

NAME OF THE PROJECT: "Sri Ramakrishna Ashrama Rural Health Services Project". The project was started in 1986.

Most of the people coming under the project area live in thatched or tiled roofed mudwalled houses but not necessarily landless. Most of them possess at least 10 cents of land each. However their houses do not have sanitary convenience such as latrines and drainage. The terrain is mostly hilly a little away from the sea coast. Our PVOH activity is in 9 villages in Thiruvananthapuram District covering a population of 1 lakh and 50 thousands. Now we have concentrated our activities to a population of fifty thousand only coming in and around our Mini Health Centres and the Rural Health Centre. We have received Rs.36,79,936 till 31-3-1990 and we spent in addition Rs. 12,54,260 as our contribution.

The Mini Health Centres and the Base Hospital have already been constructed and the construction of the RHC is nearing completion.

The data relevent to the objectives of the project, provided by the baseline survey and the data as on 31-3-1990 are as follows:

1. BASELINE SURVEY

a) Immunisation status: 1) for children (1-5 yrs)
BCG-80.4 percent, DPT-70.8 percent, Polio-69.7 percent.

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ii) Pregnant women: T.T. 81 percent (average two doses)

b) Iron and Folic acid intake (pregnant women) - 85 percent

c) Vitamin A intake (children) - 75 percent

d) 93.9 percent pregnant women had medical check-ups, 76.8 percent of currently married couples practiced F.P. methods, of these 83 percent opted for female sterilisation and 10 percent male sterilisation.

e) Lack of protected drinking water was reported from 2 centres Close-pit sanitation was extremely poor in all the centres especially Oonnampara.

DATA AS ON 31-3-1990

a) Immunisation: i) for children (1-5 yrs): DPT & Polio - over 85%
ii) Pregnant women: from service under the project and from Government and private agencies over 90% of pregnant women, had on the average two dozes of T.T.

b) Iron and Folic acid intake of pregnant women - 80 to 85%

c) Vitamin A intake children (1-5 yrs) 84%. Target set up for Registration of pregnant women and number of ante-natal examinations are almost achieved.

Trained 86 volunteers for a period of 3 months paying each Rs.250/- per month as stipend. They helped us in the project activities.

The work of the project can mainly be divided under three heads.
1- Preventive(treatment) 2. Curative (treatment) 3. Innovative schemes.

PREVENTIVE TREATMENT

Government supplied Polio, Measles, DT, D.P.T., T.T. and B.C.G. vaccines free of cost and they were administered to the needy, free of cost. 151 group meetings, 6 seminars, 6 quiz programmes and exhibitions, 23 medical camps on T.B., Leprosy, V.D. and general, 93 film shows and a few slide shows were conducted during the period for highlighting the importance of preventive health. Lectures and classes by experts from the Health Services Department, T.B. Association and Leprosy Foundation were arranged for educating the villagers on the preventive aspects of health. Classes were also conducted for our doctors, ANMs and other staff on cold chain maintenance the latest changes on dosage and spacing the injection for immunization and other allied matters by experts in the field from the Health Services Department. Classes on ante-natal and post-natal care, importance of nutritious food during the above periods, environmental hygiene, importance of cheap and available nutritious food, kitchen gardening, breast feeding,

family planning both permanent and temporary and the importance of preventive treatment were conducted forvillage level volunteers, ANMs and PHN. The village level volunteers, ANMs and the PHN also visited the houses for educating the women on the above aspects individually. Monthly check ups were conducted in village nursery schools, orphanages, tribal hostels and necessary advice was given. 241 wells were chlorinated.

In the field of family planning a large number of MTP and PPS were conducted in the main hospital for women from our project area. Insertion of Copper-T is done in MHC and RHC. During house visits ANMs supply Nirodh and advice the mothers on the importance of family planning. Film shows on family planning were also conducted.

CURATIVE TREATMENT

As far as curative treatment is concerned there are 20 beds in the Base Hospital. Curative treatment is also conducted through RHC and MHC at Cheriakonni for six days a week; in the other four MHCs at Vavode,Oonnampara, Poovachal and Keezharoor three days a week. Free medical camps with the help of District Medical Officer, T.B. Association and Leprosy Foundation are regularly conducted. After regular OP all minor treatment is done by ANMs in the MHCs. Patients who require major treatment are directed to concerned institutions.

INNOVATIVE SCHEMES

As part of innovative schemes, low cost latrines were provided for 100 households as a model. We could obtain a grant of Rs.4,97,900 from CAPART for constructing 400 latrines. It was possible for us to construct 512 latrines with the grant.

During the house visits it was observed that many could not afford thatching and repairing their houses and these had contributed to the bad health of the house hold. Some of them were helped to thatch their houses and a few new tiled houses were also constructed for the needy from our own funds. In very deserving cases uniforms and books were distributed to students in the project area at our cost. The total amount spent by the Ashrama for these comes to Rs.35,000/-. Information regarding financial help which could be had from Trivandrum Development Authority for building houses with latrines were given to the villagers.

The thrust of the project was on the preventive aspects of health. But the local people wanted curative treatment also. Therefore the pattern of the

project was changed from September 1989. Curative treatment is also being given along with preventive treatment. The RHC which was originally started as a hospital with 6 beds was converted into an OP with 6 days a week. Our aim in this change was to extend the facilities of curative treatment to the villagers with the allowed staff.

One of the important lessons we learnt from the work is that local people want curative treatment along with preventive treatment. Also it is seen that sanitary latrines are very much needed in the area. Another acute necessity is good houses. Still another item they lack is nutrition food.

As regards the objectives of the project the people are aware that we have already exceeded the targets laid down by the project.

As already stated our idea in changing the strategy of the project was to see how far we could sustain the activities now being carried out. Still the amount we receive from the mini centres, RHC and Base Hospital is not sufficient. We will watch and see how far we will be able to maintain the project. We feel that help as grant for some more time will be required before we assess whether we will be able to sustain the activities of the project on our own.

STREEHITAKARINI, BOMBAY
P.V.O.H. PROJECT OF GOI/MOHFW

A group of educated middle class women - with an urge to do some good, decided to help women to lead a Healthy, Free and Full Life. - Streehitakarini was founded in 1964. The conviction that a women could move in this direction if she could plan her family size lead to promotion of family planning and starting non formal education for women. Back to the villages was the cry of the early sixties. In search of a village in Bombay they located the industrial slums in the Dadar, Elphistone, Parel area in Central Bombay. I.U.D. insertion camps were organised in rural Maharashtra and training imparted to the local Doctors to do the insertion and removals of I.U.D. (Lippes Loop).

A medical clinic was started in the slums in 1964 as per the need expressed by the local women. This got stabilised into a regular daily clinic in 1968 when Pathfinder Fund U.S.A. granted a project on 'Community Involvement in Family Planning'. The clinic played a very pivotal role in the initial stages. A preliminary family and fertility survey of 5000 population with the help of local volunteers helped to get some insight into the physical, economical and social parameters of the residents and helped in planning our activities.

It was soon realised that child survival was very essential for the success of family planning. In fact we were the first organisation to put into practice the M.C.H. programme.

Bombay attracts large number of migrants, since housing is not available to these new poor entrants slums have sprung-up. Annual growth rate of the city is 3.6% but that of the slums is 17.40%. Streehitakarini is located in the G-Ward which has the highest slum population of 33.51%. In 1972 84.8% families were below poverty line in 1984 - 89% had reached that level as an aftermath of the long drawn textile strike of 1982.

Starting with a population of 5000 we gradually extended our activities to 0,000 population by 1984.

OUR ACHIEVEMENTS:

. Housewives from slums with 5-8 years of schooling were trained to work s multi-purpose community workers. They are now recognised as leaders of ocial change. 90% of our work force of 150 are residents of the area. Many f them have been with us for a period of 15 years or more.

. All of them are members of Streehitakarini and have a say in Planning nd implementation of the programmes.

. Developed a need based integrated developmental programme with inputs Health, Family Planning, Child Survival (Immunisation, Growth monitoring Pre-school kindergarten classes). Non formal education for women on all

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aspects of life.

4. Training for income generation.

5. Small Savings Campaign.

6. Training of Community Health workers for other institutions.

7. Developed a special teaching aid in the form of handkerchiefs to be used by the community health workers.

8. Publication of books on Child Care, Population and Nutrition, in Marathi and the translation of David Werner's book "Where There Is No Doctor".

The PVOH grant period was from 1st April, 1984 to 31st March, 1988 but was extended upto 31st March, 1989 as there was an unspent amount from the total allotment of Rs. 30,59,370/- Streehitakarini contributed 25% of the cost of the Project. Under this project additional 40,000 population was adopted the total being 1,00,000.

A base line survey of 15,000 families was done - 10% random sample i.e. 1514 cards were selected for analysis. The evaluation survey of the same sample cards was done in 1988 as per the original plan. If the old family was not living in the same location the card was not replaced. In all 1048 respondent families were available.

Non-availability of Respondent Families

Change of Residence	Sold and gone to Native Place	Demolition of houses	Death of Respondents	T o t a l
346	48	68	4	466

Practice of leasing out the premises for a period of eleven months results in change of residence often within the locality. Those who improve in their economic status also tend to move out.

Due to the heterogenicity of the slum population the households were classified according to region from which they migrated.

	Maharashtra	Gujarath	Andhra Pradesh	U. P. Bihar	O t h e r
1984	64.4	6.5	12.0	9.9	7.2
1988	60.6	5.9	18.1	10.8	3.6

STREEHITAKARINI, BOMBAY
P.V.O.H. PROJECT OF GOI/MOHFW

During 1984-88 families have become poorer. Families having per capita income of Rs.200/- per month or less have gone up from 56.8% to 61.3% due to the continuing effects of the long drawn textile strike. Many persons had to accept jobs with much lower income. 32% of women acepted some unskilled or mannual occupation as against 26.1% earlier. This rise in occupation of women was also partly due to the rise in Andhra families - mainly as bidi workers.

WEIGHT OF WOMEN (%)

	Good	Fair	Poor
1984	12	22	66
1988	8	63	29

ACCEPTANCE OF FAMILY PLANNING METHODS(5)

	Nil	Condoms	I.U.D.	O.C.	Sterilisation	
					Female	Male
1984	46.2	2.0	2.9	1.4	45	2.5
1988	28.1	2.9	4.6	2.5	56	5.9

Care in pregnancy had improved. Tetanus toxide 2 doses coverage was 84.3%.

BREAST FEEDING (%)

	Nil	24 Hrs	Within 48 Hrs	64 Hrs
1984	19.5	26.7	22.5	31.3
1988	0	56.0	40.0	4.0

IMMUNISATION (%)

	BCG	DPT,POLIO	MEASLES	NIL
1984	73.8	68.2	0.2	20.4
1988	90.0	88.0	18.7	10.0

Supplementary Nutrition was given to 5000 children between 1 & 5 years and included 250 lactating and pregnant women. PVOH grant support was for only 3000.

NUTRITION AND GENERAL HEALTH
CHILDREN 1 - 5 YEARS

	Nutrition			General Health		
	Good	Fair	Poor	Good	Fair	Poor
1985	35.4	33.4	8.4	13.8	75.9	10.3
1988	50.0	30,2	3.8	23,8	67.5	8.7

STREEHITAKARINI, BOMBAY
P.V.O.H. PROJECT OF GOI/MOHFW

The PVOH grant helped us to consolidate, strengthen and expand our activities to a larger population. Putting into practice our positive experiences in organising the various activities we could achieve the same health indices in the expanded population within a short period.

With 30.8% of in migration and out migration, a considerable urban rural exchange of family members, the natural aging of the population requiring inputs for the maturing youth, the activities have to be continuous and innovative.

SILVER JUBILEE YEAR 1988-89:

Additional 10,000 population totally identified and recommended by our health workers taken under our fold.

- Healthy Mother and Child Competition.
- Nutritious Recipe Competition - 300 women participated.
- Bal Melawa - Educational and Cultural Camp for children 7 - 13 years for one week - 1300 children participated.
- Cancer Detection organised for 1,000 women from the area with the help of Cancer Research Society.
- Conference on 'Womens Institutions and Social Change' - 100 delegates.
- Poster Competition on Women and her problems under the guidance of Mr Hanumante Ex. Dean J.J. School of Arts.

FURTHER PLANS:

Research cum Service Project on Gynaecological problems of women.
Second chance to Adoloscent girls project.
Both Ford Foundation Sponsored.

- Non-formal education programmes for adoloscent boys and girls to help them grow into responsible, rational, thinking citizens.

A health post has been alloted to us by Bombay Municipal Corporation.

Present activities to continue.

THE LEPROSY MISSION INDIA
P.V.O.H. PROJECT OF GOI/MOHFW

CONTROL/ERADICATION OF LEPROSY THROUGH COMMUNITY HEALTH EDUCATION

Introduction

The Leprosy Mission is an international interdenominational christian organisation bringing healing to many leprosy patients in over 30 countries. This is done both directly and in cooperation with many churches, governments and voluntary groups. The aim of the Mission is to meet the total needs (physical, spiritual, social, psychological) of people affected by leprosy and to work towards eradication of the disease.

Brief History -The Leprosy Mission

Mr. Wellesly Cosby Bailey Founder of the Leprosy Mission was drawn with a strong sense of love and compassion when he visited a Leprosy Asylum in Ambala in 1874, where he worked as a teacher in a mission school. On his return to Dublin in Ireland he carried with him the sympathy towards these unfortunate ones. He spoke of his concern for helping leprosy patients. His address to his friends brought conviction to one Irish woman Charlotte Pim who pledged to raise £ 30 each each year to help Mr Bailey. With this small sum the Mission was started and came to be called 'MISSION TO LEPERS'.

It is now known as THE LEPROSY MISSION INDIA. The Leprosy Mission works in close cooperation with the Government of India, and other international agencies like UNICEF, US AID etc. in achieving the objectives of the National Leprosy Eradication Programme.

Starting with one small clinic it today has 30 hospitals in India working in close association with 28 other christian agencies involved in health activities.

Activities of the Leprosy Mission - India

Care of patients has been the prime concern of the Mission since its establishment. 'Care after Cure' is what the Leprosy Mission emphasizes after introduction of Multi Drug Therapy (MDT) in all its hospitals all over India. Physiotherapy, surgery and occupational therapy form the basis for rehabilitation. The Leprosy Mission has all these facilities in its 30 hospitals. It also has 3 artificial limb centres, 2 health education units, 6 regional schools for children affected by leprosy. These schools have vocational training as part of their curriculum; 6 training centres for training medical and para medical personnel and one Vocational Training Centre which gives an opportunity to learn stenography, printing,

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tailoring, automechanics and welding. Computer training is to be shortly introduced.

There are new areas where the Leprosy Mission is reaching its services.

Kerala: Government has given permission to start work in Manjeri in Malappuram district in North Kerala. The Leprosy Mission has also sought permission for leprosy control work in Quilon.

Nagaland: Health education activities were started in May'90 involving the church leaders in Mon and Longleng in collaboration with the Nagaland Baptist Church Council.

The Leprosy Mission has also placed a request to start work in the islands of Andaman and Nicobar.

Programme Activities

In January 1987, the Government of India entrusted the Leprosy Mision with a US AID supported programme "Control/Eradication of Leprosy Through Community Health Education". One of the aims of this programme was to acquaint the public in the districts of Bankura (W.B.), Barabanki (U.P.) and East Godavari (A.P.) through sustained health education the true nature of leprosy with a view to removing age old prejudices and instilling confidence in total cure through early reporting/detection. Alongside health education in the said districts MDT commenced sometime during October-December 87. Yet another task assigned was to produce a set of 16 video programmes on diagnosis and management of leprosy and on communication skills to train medical practitioners and students. Another 16 programmes were to be produced for use mainly in health education activities with a view to changing community opinion and attitudes about leprosy. Finally, the Mission was to cater for training of U.P.State personnel involved in anti-leprosy work at its Training Centre at Naini (Allahabad); simultaneously the Mission was called upon to create a leprosy control area in the close vicinity of Naini to train field personnel as well as conduct survey, education and treatment activities.

Programme Achievements

Through dedicated efforts of the various team members results deeply appreciated by the Governmentmonitoring agencies have been achieved so far.

The prevalence rates in the districts under MDT has been brought down from a high of 12.1 per thousand in Dec 87 to 2.40 per thousand in March 90.

Through vigorous, sustained and well organised health education by specially selected and fully trained health workers and district leprosy officer's staff, a total of 21,810 new cases were administered treatment between commencement of MDT and March 90.

(Assisted by the U.S.A.I.D.)

The video cassettes produced under the programme have been distributed to approved medical colleges, institutions and leprosy hospitals. The content, quality and presentation of these programmes have been appreciated. It would not be out of place to mention that these cassettes are in great demand in this and other countries.

Naini field control area has been fully organised and the first survey is nearing completion. A total of 3238 cases are now under treatment. Various categories of U.P. State workers have and are still receiving training at Naini using latest teaching techniques under strict supervision.

Lessons Learnt

Delay in commencement of programme activities could have been avoided with advance planning and placement of vehicles, equipment and selection of personnel including their training prior to start of various planned activities.

As Leprosy Mission hospitals responsible for conduct of IEC activities are loacated far from main centres of trade and communication, there was a need to provide certain essential standby equipment e.g. generator, projector to avoid excessive loss of time in repairs.

The Leprosy Mission hospitals being far removed from main cities, it was difficult to obtain workers from the open market. The situation was further aggravated as the IEC team had to move out each day (at least 4 to 5 days a week) for conducting health education from early morning and returning late at night after conducting film shows. It was therefore essential to provide accommodation and or food to team members at the Leprosy Mission hospital as well as be paid a higher rate of consolidated salary.

For timely financial support to all activities it is considered most necessary that at least 3 months grant (advance) be available with each grantee to tide over delays in release of quarterly instalments.

Health education to be fully effective must be repeated, say on a quarterly / half yearly basis. Taking into consideration a near 6 month delay in commencement of activities and a total programme time of only 2 years 9 months, the health education was hurried in the earlier stages. With the programme extension by one year it has been possible to cover a fair number of centres. If therefore the programme period is short then two teams with adequate resources must function simultaneously or else at leat 4 years should be considered just about adequate to cover a district.

Planned training should not be changed at short notices. Moreover, those responsible for nominating trainees should personally ensure proper selection and full utilisation of training capacity. In this case experience of Naini Training Centre in training Uttar Pradesh leprosy related field personnel has not been a meaningful one. Instead of train ing 100 NMS, 60

health educators, 30 lab technicians, 50 doctors in the vertical programme, only 80 NMS, 26 lab technicians and 84 NMAs have been trained till 30 June 90. One NMS (25 vacancies) and 4 lab technicians' courses (5 vacancies each) are scheduled in the remaining programme period.

Maximum stress was laid on covering as many and all grades of schools in health education activities.

Health education is a continous subject and the more vigorously and continuously it is carried out will it greatly assist in unearthing maximum if not all leprosy cases and in removing the stigma, misconceptions and fears associated with LEPROSY.

Continuation Activities After September 1990

Health education on a regular basis will continue to be imparted by the Leprosy Mission workers in their control area as planned by the respective hospital Superintendents. Remaining portion of 'Intensive Phase' of MDT and subsequent maintenance phase will continue under direction of Central / respective State Governments. The Leprosy Mission, Naini Training Centre will continue its training schedule under direction of the Leprosy Mission Training Coordinator. Superintendent, The Leprosy Mission Naini Hospital will continue with SET activities in its Field Control Area. Karigiri video is in the process of drawing up its plans for production of video cassettes on various medical subjects including leprosy as well as on health education under directions of the Director, Schieffelin Leprosy Research and Training Centre, Karigiri. Expenditure in connection with the above activities less on MDT will be the responsibility of the Leprosy Mission and Schieffelin Leprosy Research and Training Centre.

IEC/MDT district - Profile

Districts	East Godavari	Barabank	Bankura
Population	37,010,40	19,920,74	23,742,05
Villages	1,389	1,556	3,264
Area (Sq Km)	10,807	4,401	6,881

VOLUNTARY HLTH.SERVICES, MADRAS
P.V.O.H. PROJECT OF GOI/MOHFW

I. BRIEF HISTORY OF THE ORGANIZATION

The Voluntary Health Services (VHS)was registered as a non profit non-governmental Society in the year 1958. Dr.K.S.Sanjivi the Founder Architect of the concept of voluntary contribution to the health services for supplementing governmental efforts had the following main concepts while developing the institution:

1. Emphasis on prevention
2. Family should be the unit for care with emphasis on maintenance of health records
3. Community participation - logistic,supervisory and financial
4. Training and research directed towards tackling of commonly prevalent problems in the community

From that time onwards the VHS has grown as a comprehensive, community hospital housing all specialities and superspecialities and now functions as a referal hospital providing supportive preventive, promotive, diagnostic, curative and re-habilitative services to the community living in the rural areas of the adjacent Chingleput District and to people living in the urban slums in the southern parts of the Madras City. To further the objective of development of low cost alternative approaches the M.A.Chidambaram Institute of Community Health has been started as a Unit of VHS and is supported by the MAC Educational & Medical Foundations and is totally devoted to the cause of Primary Health Care.

The most unique feature of the VHS is that every brick is donated by individual donors, trusts and societies. The VHS has been supported by the successive Tamil Nadu Governments in the form of bed maintenance and support to individual projects. The entire society is functioning with the concept of 'Shram Dann' and if it is what it is today is due to the cumulative efforts of several medical and para medical workers ably supported by several philanthropists.

The VHS from the beginning has been modelled as a community hospital intended for taking care of the community living in areas adjacent to it. With this area concept in view, the community health department was one of the first departments to be started.

The Mini Health Centre(MHC) model for the delivery of comprehensive health services at a low cost was evolved after a series of operational experiments in the mid sixties to work out the ideal population coverage and the staff to be deployed.Dr.K.S. Sanjivi and Dr.K.Venkateswara Rao are the authors of these concepts and experiments.

(Assisted by the U.S.A.I.D.)

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In the late sixties the model of the MHCs took shape and were put on ground in some rural areas of Chingleput District of Tamil Nadu State. The ideal set up for MHC as evolved is:

a. A health post manned by Lay First Aider for every 1000 popl.
b. A male and a female Multipurpose Worker for every 5000 popl.
c. A doctor being available at the MHC level for at least three hours a day on three days a week.
d. The identification of, and liaison with, a referal hospital within a reasonable distance.

II.(a).DESCRIPTION OF ACTIVITIES DONE THROUGH THE PVOH GRANT

Under the PVOH grant the VHS established 32 MHCs for rendering Primary Health Care. Taking into account the high prevalence of Leprosy and Tuberculosis in the area of operation the project proposals envisaged controlling these two diseases in an integrated manner along with the primary health care services which are normally being delivered through the MHCs. Each MHC covers a population of 5000; care has been taken to see that there is no sub centre or primary health centre in the area of the MHCs. The project area is located in the Chingleput District spread over parts of two community development blocks viz.St.Thomas Mt. and Tiruporur. The project area is spread over 70 Kms. from the southern most end of the Madras City. The villages served by the project area are representative of the typical rural setting elsewhere in Tamil Nadu. The families served belong to the poorsocioeconomic status, predominant occupation being agricultural labour. The population served by the project is 1.6 lakhs. The popl. consists of 79958 males and 72090 females; of this 3199 are 0-1 year and 15902 are 1-5 year children. 72% of the populationare economically weaker sections. 43% of population are living below the poverty line.

ACTIVITIES OF THE PROJECT

Conduct of the census was the first and foremost activity in the project area. The families were encouraged to become subscribers in the prepayment plan. The subscription varies according to the income status of the family. The amount of subscription works out to 0.75% of the annual income. The preventive and promotive services are offered to all inhabitants irrespective of their membership status. However, the curative care is available free to subscribers and on payment of a fee to non subscribers. All the individuals in the family are checked up once a year for detecting health problems. By this approach we could find 95% of the population required some sort of assistance.

(Assisted by the U.S.A.I.D.)

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Family folders are maintained and the complete medical and developmental history of all the members of the family is entered in these folders.

The primary health care system starts at the remote villages at the hands of the Lay First Aider(LFA) manning the health post. This LFA is always a middle aged woman who acts as an health informant and communicates the health events to the multipurpose workers. In addition, she will also visit the houses to know the current health status, as well as for follow up by the professionals at the MHC. She also provides few basic medicines at times of need at her health post.

Based on the information provided by the LFAs pregnant mothers are registered and followed up by routine antenatal care until the delivery. Disposable Delivery Kit is provided to each pregnant mother to be given to the birth attendant during the time of delivery. Skilled assistance is provided for ensuring aseptic deliveries. The health workers liaise with the Traditional Birth Attendants and give training to them in the conduct of safe and aseptic deliveries. High Risk mothers having previous bad obstetric histories, severe anaemias and other medical problems are referred to the hospital.

The children are assured of total protection against vaccine preventable diseases as per the prescribed time schedule. Growth of the children is monitored regularly. Nutritional supplements are provided to children of Grade III malnutrition. Appropriate nutritional supplements are also given to pregnant mothers during the last trimester to combat the problem of low birth weight. The mothers are educated about the oral rehydration therapy in the prevention of morbidity and mortality following diarrhoea. Preparation of sugar and salt solution is demonstrated to them in the health education sessions. Periodic deworming is attempted to improve the health status of children. Health check up for school children is an important activity of the mini health centre in the area.

Prevention of communicable diseases as an integral part of the comprehensive health services is a sheet-anchor of the mini health centre activities. Consequent to the regular house visiting, screening for malaria, leprosy, tuberculosis and other communicable diseases, becomes a routine. Sputum cups are distributed to all the symptomatics. The sputum smear is fixed and examined for the presence of Tubercle bacilli. Then suspected cases are taken to the referal hospital for an X-ray

for the detection of radiologically positive cases. After confirmation, the patients are put on domiciliary treatment on standard regimens. The patients are regularly followed up tor control and treatment default and examined at prescribed intervals to assess the progress of treatment. All the cases suspected to be having a skin patch are examined for the presence of anaesthesia and treatment offered at the doorsteps without much publicity to avoid their social stigmatisation. The patients are put on modern multi-drug regimen. Microcellular rubber shoes are distributed to the leprosy patients to prevent trophic ulceration.

Health education is a regular activity in the MHC. In addition to person to person approach, group discussions and audio visual shows are conducted. Nutrition education is provided for the usage of locally available food stuffs and in the preparation of low cost weaning foods. Regular nutrition demonstration sessions are organised at the village level. Weaning food packets are available at subsidised rates with LFAs. These foods are very popular with the villagers. Seeds for the development of Kitchen gardens are distributed free of cost to the community. The emphasis is on the growth of dark green leafy vegetables.

The VHS with its specialities and super specialities, is the referal hospital for all the MHCs in the area and provides tertiary support to the rural health posts/MHCs.

The MHC scheme emphasises community participation which is three fold. The community provides accommodation and minimal furniture. A non political local action committee is constituted for a two way liaison between service providers and the beneficiaries. There is financial participation by the community in the form of subscriptions or fee for service.

II.(b). CHANGES IN HEALTH INDICATORS SINCE THE START OF THE PROJECT

	1984	Jan.1990
Crude Birth Rate	30.6/1000	21.7
Crude Death Rate	11.9/1000	7.0
Infant Mortality Rate	86.5/1000 lbs	36.5
% of immunisation coverage among eligible children and AN mothers(U.I.P.)	18	65.3
% of antenatal registration of pregnant women	30	80.2

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	1984	Jan.1990
% of deliveries conducted by trained health workers	15	40.7
% of mothers receiving postnatal care	31.5	90.1
% of children covered by child Welfare Services	25	84.5
Leprosy cases on hand	1744	207
Tuberculosis cases on hand	(Est.) 20/1000	981
% of Couples protected	23	40.2

III.(a) IMPORTANT OBSERVATIONS DURING THE PROJECT IMPLEMENTATIONS

1.Low priority to health 2. Constraints in paying for health care 3. Non recognition of importance of voluntary work by lower officials in Government Heirarchy 4. Turnover of staff 5. Lack of committed people 6. Thinning of philanthropy.

III.(b) SUSTAINING ACTIVITIES

The MHC scheme developed by the VHS is being implemented by several other voluntary organisations in the State. We wish to bring the additional MHCs established under the PVOH project on par with the rest of the MHCs so that they become eligible for the 1:1:1 pattern of the financial support. The community Health Department of VHS and MAC-ICH will provide all the logistical support for continuing the TB and Leprosy control activities initiated under the project. We have applied for the SET grant to the Government of India for continuation of Leprosy control activities on the long-term basis.

It is our dream that all the health expenditure by the Central, State, local bodies,organised sectors and voluntary spending should be pooled into common resource pool and there should be a single uniform channel for providing primary health care services irrespective of their economic status or geographic domicile. Community contribution should also be pooled into this resource pool. This Community Healtn and Education Development Combines (COHEDEC) will be totally responsible for the delivery of health services on an area concept. If necessary, for the mobilisation of resources, a small health cess may be contemplated.